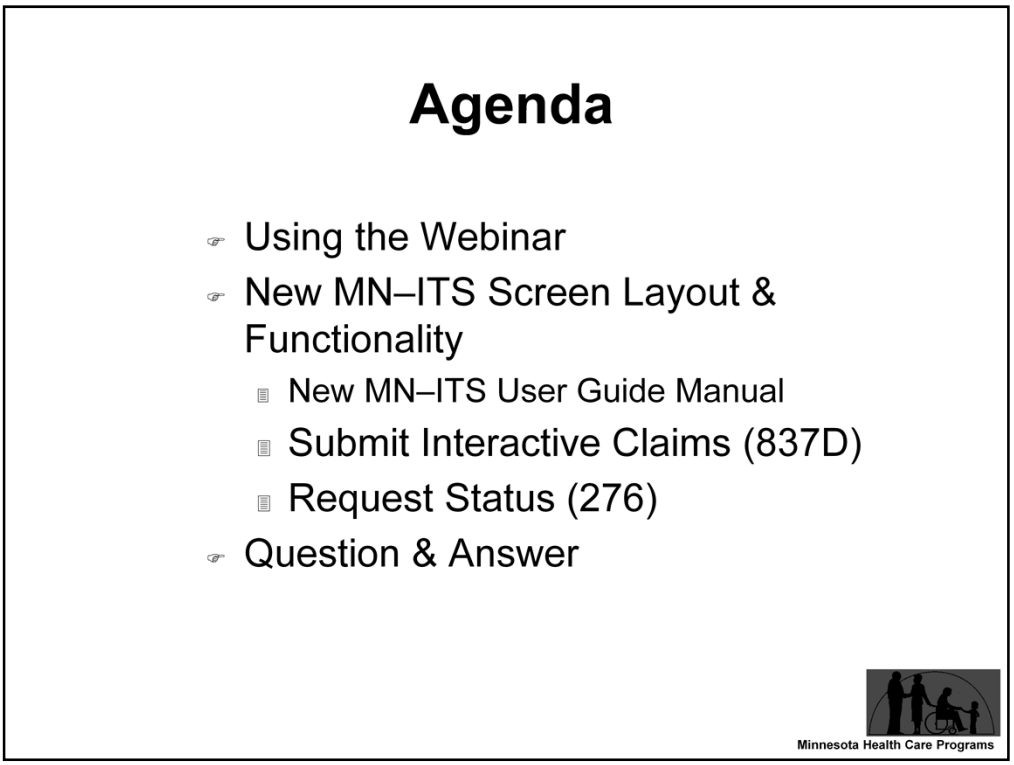
New MN–ITS Screens (837D) Dental with Line Level COB

Minnesota Health Care Programs (MHCP)

Minnesota Department of Human Services

Welcome to the Minnesota Health Care Programs webinar on the new MN-ITS screen changes to the 837D, Dental claim.

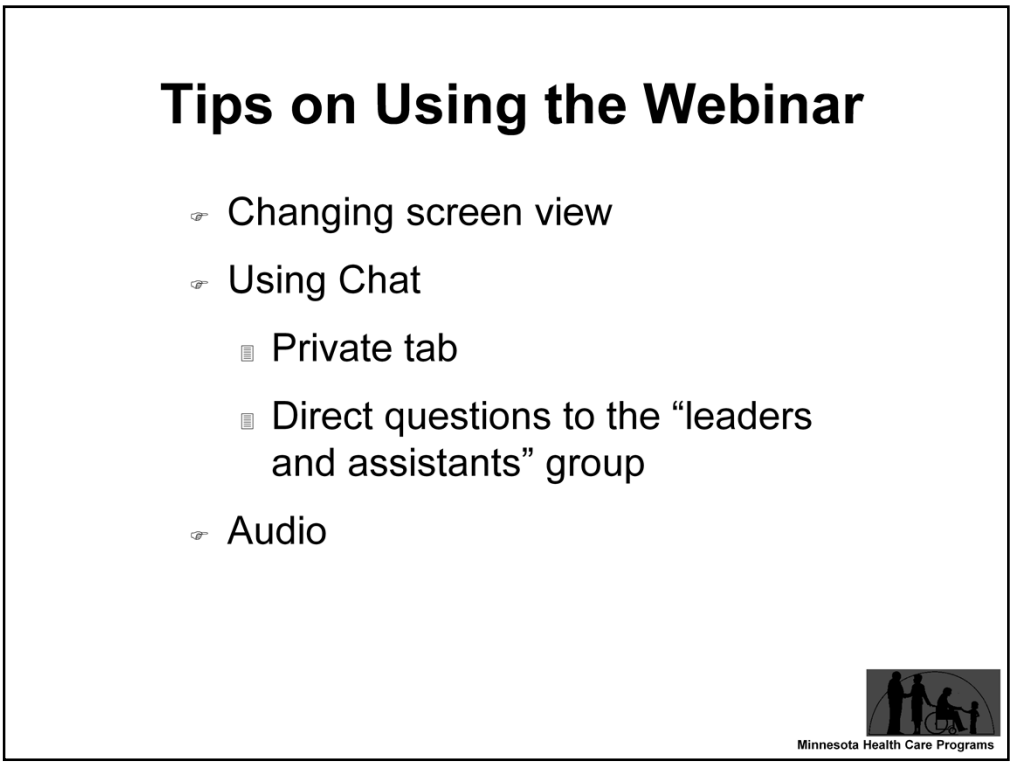
In this webinar we will review the new look and functionalities of the new 837D MN–ITS screens. We will also review how to submit a secondary claim with Third Party Liability also known as COB to MHCP to receive reimbursement at the line level. The new screens became available on Monday September 9, 2013.



During this webinar, we will discuss:

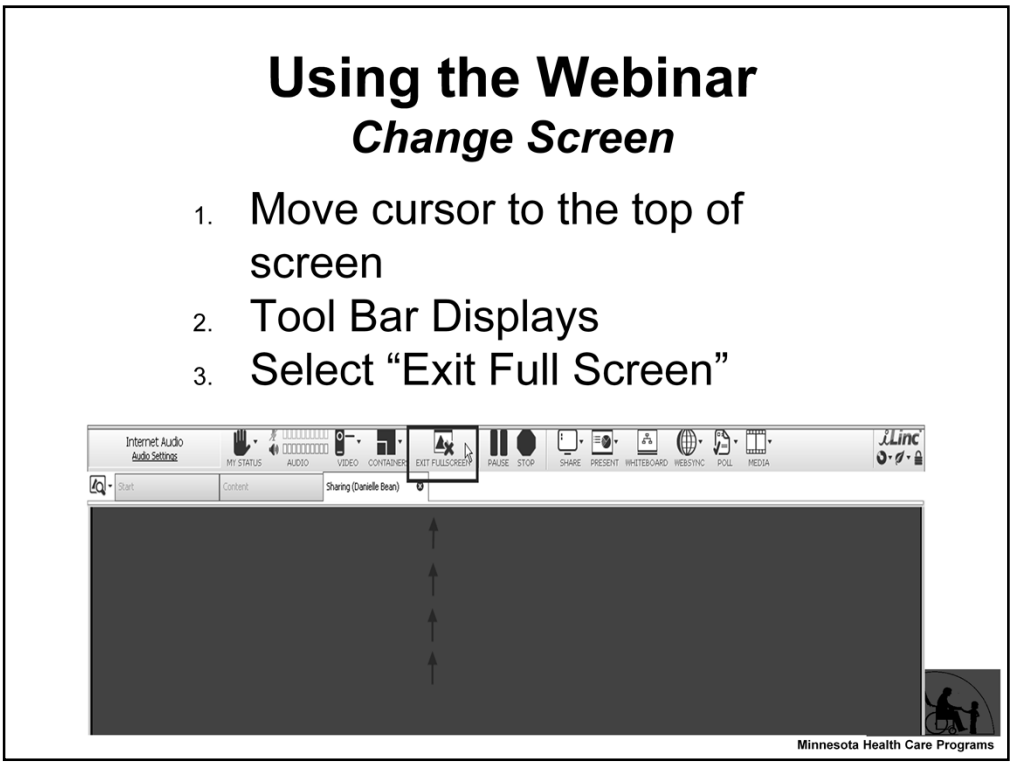
- Using the Webinars features to successfully hear, view the presentation; and also how to submit your questions
- We will also review the new MN-ITS screen layout, and how to navigate throughout the applications including the new:
    - MN–ITS User Guide Manual
    - Submit Direct Data Entry (DDE) (837D) Claims and Request Status (276) transactions

There will be question and answer session following each section of the presentation today. However you are welcome to submit questions at anytime during the presentation.



Before we begin, I would like to show you some tips for using the webinars features such as:

- Changing your screen view
- Using the Chat feature
- And suggestions for audio quality



If you find that your view has changed to full-screen mode, these options will restore the webinar display:

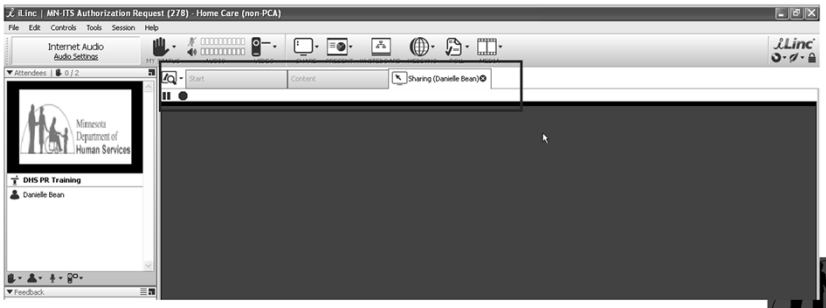
- Move your cursor to the top of the screen
- A tool bar will drop down and display several options
- Select the “Exit Full Screen” option

Once you have exited the full-screen mode, you will see the three tiered webinar display, with:

- The menu bars on top
- The chat feature on the left side, toward the bottom of the screen
- And the presentation in the center

Using the Webinar
Sharing Tab

- Select Sharing tab to see presentation if screen is blank

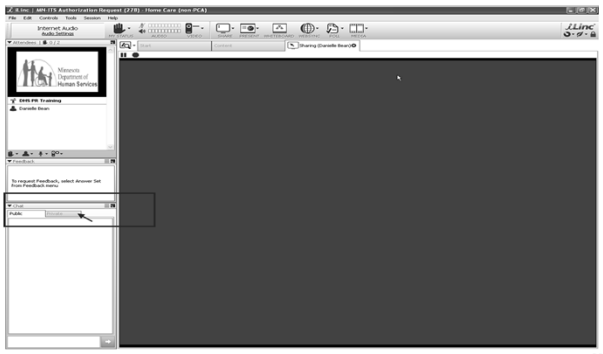


Minnesota Health Care Programs

If you get stuck on a blank screen or end up back on the start page, make sure you select the sharing tab, in the top center of the display, to return to the presentation.

Using the Webinar
Chat

1. To chat select the private tab
2. Select “leaders and assistants group”
3. Type your question/comment
4. Select enter to send



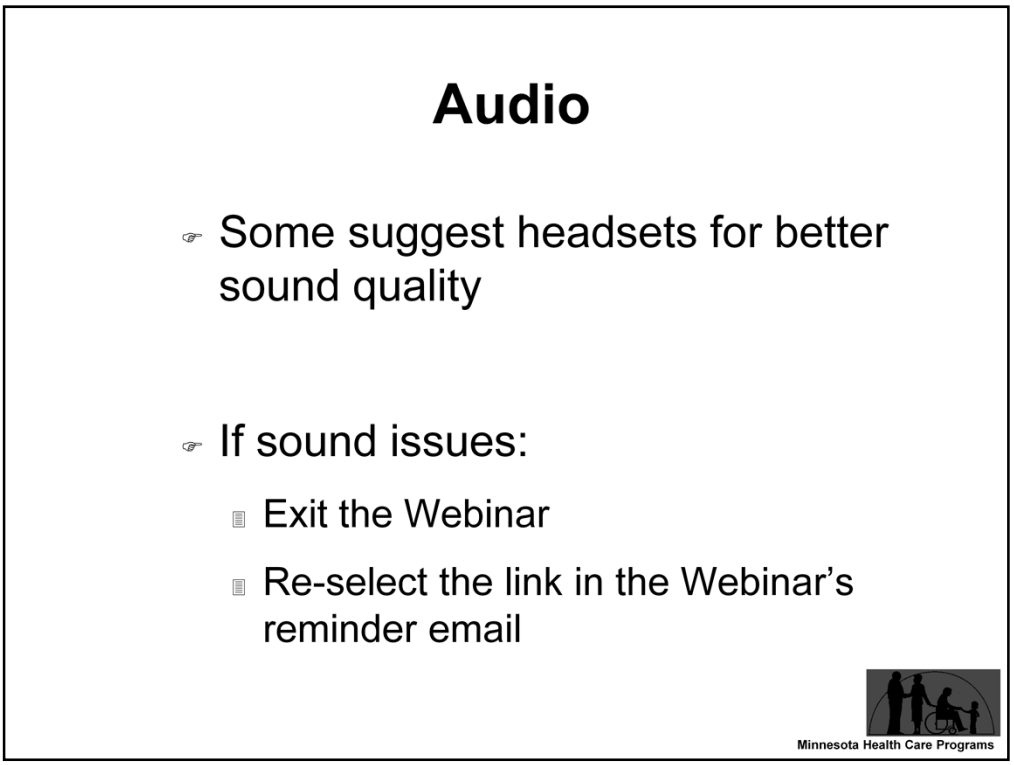
Minnesota Health Care Programs

As mentioned earlier, questions will be answered at the end of each section during the presentation. However, if you are experiencing technical issues or you wish to submit a question, please use:

The chat feature that is located in the lower left of your webinar display:

- Select the private tab
- Select Leaders and Assistants group
- Type in your question or comment
- Select enter to send

I (we) will respond to your technical issues as quickly as possible.


Audio
Some suggest headsets for better sound quality
If sound issues:
Exit the Webinar
Re-select the link in the Webinar's reminder email
Minnesota Health Care Programs

Some people suggest headsets provide better sound quality. However, you may listen to the webinar through your computer speakers as well.

If you experience sound issues:

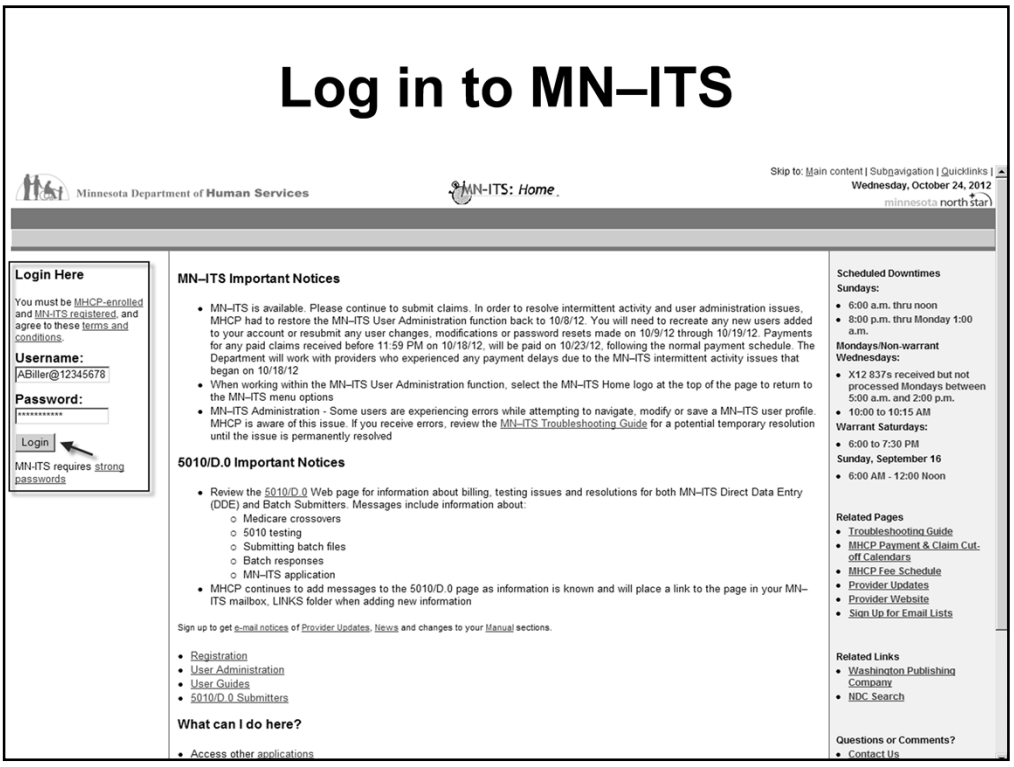
- Exit the webinar by closing the window
- Log back in to the webinar using the link in the reminder email that was sent to you

New MN–ITS Screens

Layout and Functionality

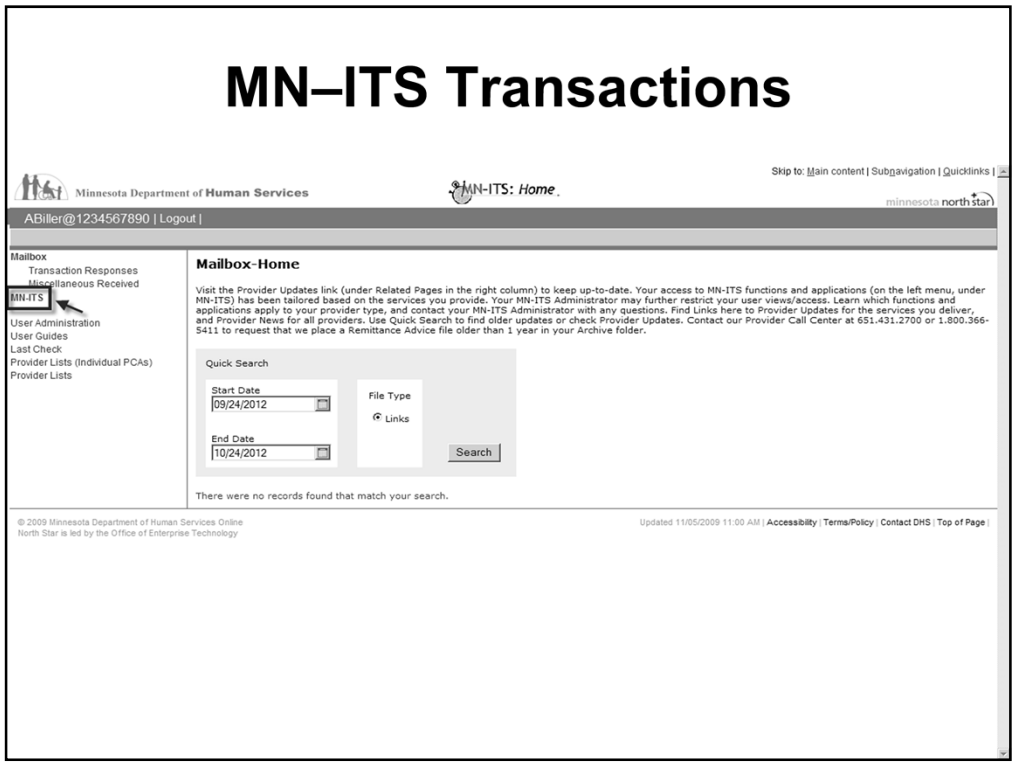
Now we will begin our presentation of the new MN-ITS screen changes; their layout and navigation functionality.

Log in to MN–ITS


Minnesota Department of Human Services
MN-ITS: Home
Skip to: Main content | Subnavigation | Quicklinks |
Wednesday, October 24, 2012
minnesota north star
Login Here
You must be MHCP-enrolled and MN-ITS registered, and agree to these terms and conditions.
Username:
ABiller@12345678
Password:
Login
MN-ITS requires strong passwords
MN–ITS Important Notices
MN–ITS is available. Please continue to submit claims. In order to resolve intermittent activity and user administration issues, MHCP had to restore the MN–ITS User Administration function back to 10/8/12. You will need to recreate any new users added to your account or resubmit any user changes, modifications or password resets made on 10/9/12 through 10/19/12. Payments for any paid claims received before 11:59 PM on 10/18/12, will be paid on 10/23/12, following the normal payment schedule. The Department will work with providers who experienced any payment delays due to the MN–ITS intermittent activity issues that began on 10/18/12
When working within the MN–ITS User Administration function, select the MN–ITS Home logo at the top of the page to return to the MN–ITS menu options
MN–ITS Administration - Some users are experiencing errors while attempting to navigate, modify or save a MN–ITS user profile. MHCP is aware of this issue. If you receive errors, review the MN–ITS Troubleshooting Guide for a potential temporary resolution until the issue is permanently resolved
5010/D.0 Important Notices
Review the 5010/D.0 Web page for information about billing, testing issues and resolutions for both MN–ITS Direct Data Entry (DDE) and Batch Submitters. Messages include information about:
Medicare crossovers
5010 testing
Submitting batch files
Batch responses
MN–ITS application
MHCP continues to add messages to the 5010/D.0 page as information is known and will place a link to the page in your MN–ITS mailbox, LINKS folder when adding new information
Sign up to get e-mail notices of Provider Updates, News and changes to your Manual sections.
Registration
User Administration
User Guides
5010/D.0 Submitters
What can I do here?
Access other applications
Scheduled Downtimes
Sundays:
6:00 a.m. thru noon
8:00 p.m. thru Monday 1:00 a.m.
Mondays/Non-warrant Wednesdays:
X12 837s received but not processed Mondays between 5:00 a.m. and 2:00 p.m.
10:00 to 10:15 AM
Warrant Saturdays:
6:00 to 7:30 PM
Sunday, September 16
6:00 AM - 12:00 Noon
Related Pages
Troubleshooting Guide
MHCP Payment & Claim Cut-off Calendars
MHCP Fee Schedule
Provider Updates
Provider Website
Sign Up for Email Lists
Related Links
Washington Publishing Company
NDC Search
Questions or Comments?
Contact Us

First, providers will log in to MN–ITS as they currently do entering they individual username and password.

MN–ITS Transactions


Skip to: Main content | Subnavigation | Quicklinks |
Minnesota Department of Human Services
MN-ITS: Home
minnesota north star
ABiller@1234567890 | Logout |
Mailbox
Transaction Responses
Miscellaneous Received
MN-ITS
User Administration
User Guides
Last Check
Provider Lists (Individual PCAs)
Provider Lists
Mailbox-Home
Visit the Provider Updates link (under Related Pages in the right column) to keep up-to-date. Your access to MN-ITS functions and applications (on the left menu, under MN-ITS) has been tailored based on the services you provide. Your MN-ITS Administrator may further restrict your user views/access. Learn which functions and applications apply to your provider type, and contact your MN-ITS Administrator with any questions. Find Links here to Provider Updates for the services you deliver, and Provider News for all providers. Use Quick Search to find older updates or check Provider Updates. Contact our Provider Call Center at 651.431.2700 or 1.800.366-5411 to request that we place a Remittance Advice file older than 1 year in your Archive folder.
Quick Search
Start Date
09/24/2012
End Date
10/24/2012
File Type
Links
Search
There were no records found that match your search.
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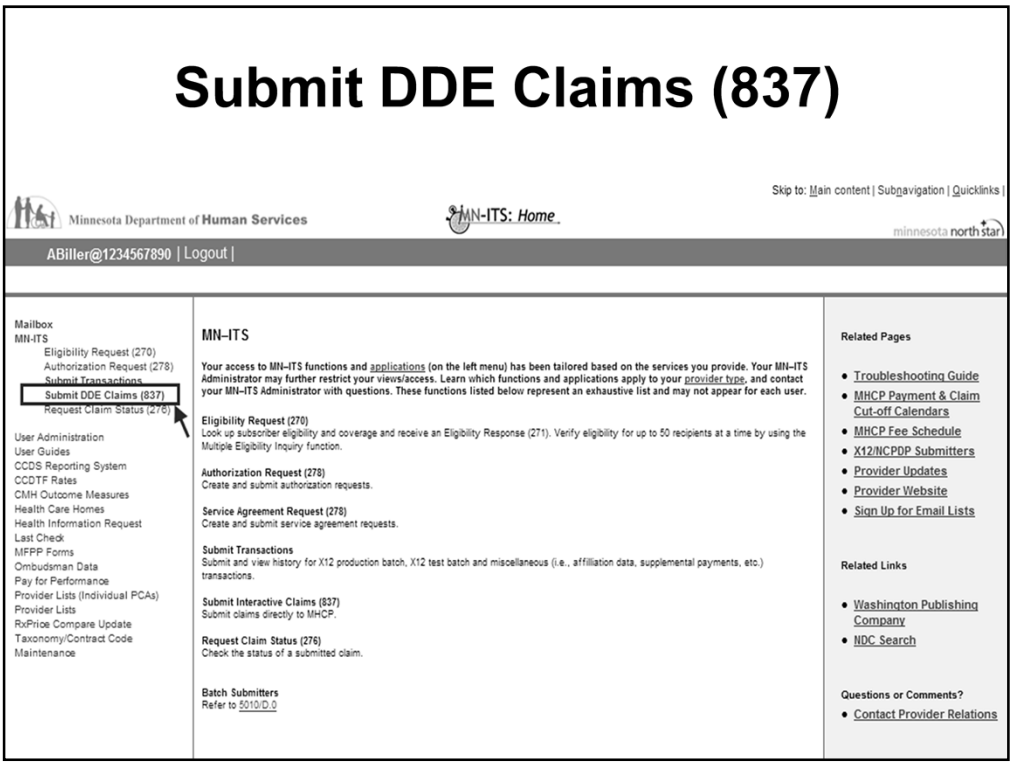
Updated 11/05/2009 11:00 AM | Accessibility | Terms/Policy | Contact DHS | Top of Page |

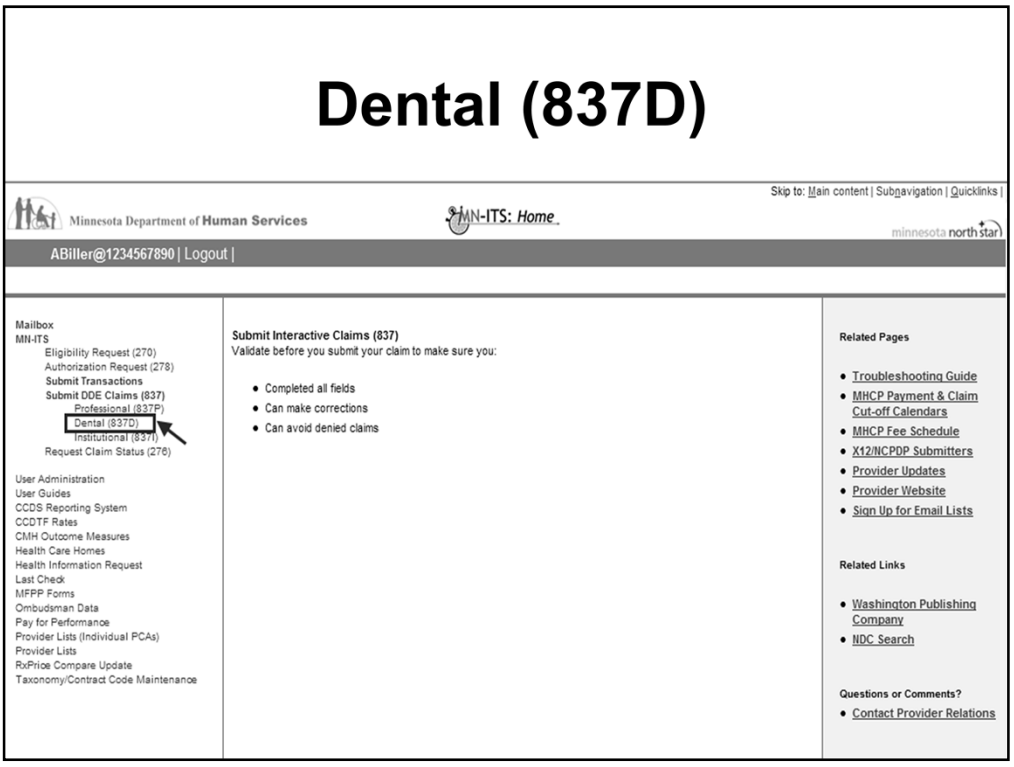
Once logged in MN-ITS will open to the Mailbox – Home page that may contain provider news messages and provider updates. From the left navigation menu select **MN-ITS**.

Submit DDE Claims (837)


Skip to: Main content | Subnavigation | Quicklinks |
Minnesota Department of Human Services
MN-ITS: Home
minnesota northstar
ABiller@1234567890 | Logout |
Mailbox
MN-ITS
Eligibility Request (270)
Authorization Request (278)
Submit Transactions
Submit DDE Claims (837)
Request Claim Status (276)
User Administration
User Guides
CCDS Reporting System
CCDTF Rates
CMH Outcome Measures
Health Care Homes
Health Information Request
Last Check
MFPP Forms
Ombudsman Data
Pay for Performance
Provider Lists (Individual PCAs)
Provider Lists
RxPrice Compare Update
Taxonomy/Contract Code Maintenance
MN–ITS
Your access to MN–ITS functions and applications (on the left menu) has been tailored based on the services you provide. Your MN–ITS Administrator may further restrict your views/access. Learn which functions and applications apply to your provider type, and contact your MN–ITS Administrator with questions. These functions listed below represent an exhaustive list and may not appear for each user.
Eligibility Request (270)
Look up subscriber eligibility and coverage and receive an Eligibility Response (271). Verify eligibility for up to 50 recipients at a time by using the Multiple Eligibility Inquiry function.
Authorization Request (278)
Create and submit authorization requests.
Service Agreement Request (278)
Create and submit service agreement requests.
Submit Transactions
Submit and view history for X12 production batch, X12 test batch and miscellaneous (i.e., affiliation data, supplemental payments, etc.) transactions.
Submit Interactive Claims (837)
Submit claims directly to MHCP.
Request Claim Status (276)
Check the status of a submitted claim.
Batch Submitters
Refer to 5010/D.0
Related Pages
Troubleshooting Guide
MHCP Payment & Claim Cut-off Calendars
MHCP Fee Schedule
X12/NCPDP Submitters
Provider Updates
Provider Website
Sign Up for Email Lists
Related Links
Washington Publishing Company
NDC Search
Questions or Comments?
Contact Provider Relations

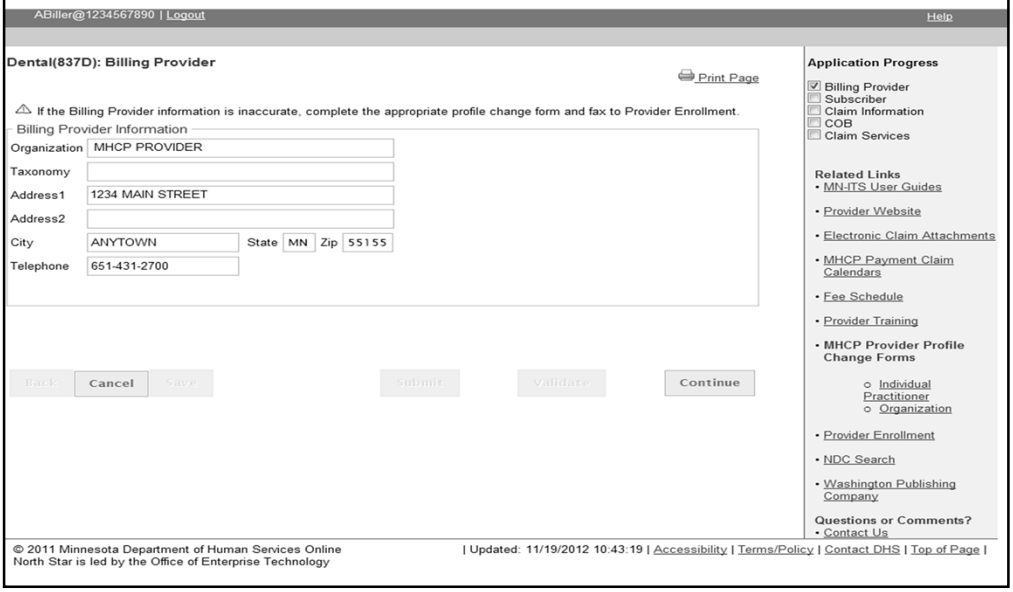
Next from the left navigation under MN–ITS select **Submit DDE Claims (837).**

Dental (837D)



From the left navigation, under Submit DDE Claims select **Dental (837D)** to go to the new dental claim screens.

Dental (837D)
Billing Provider



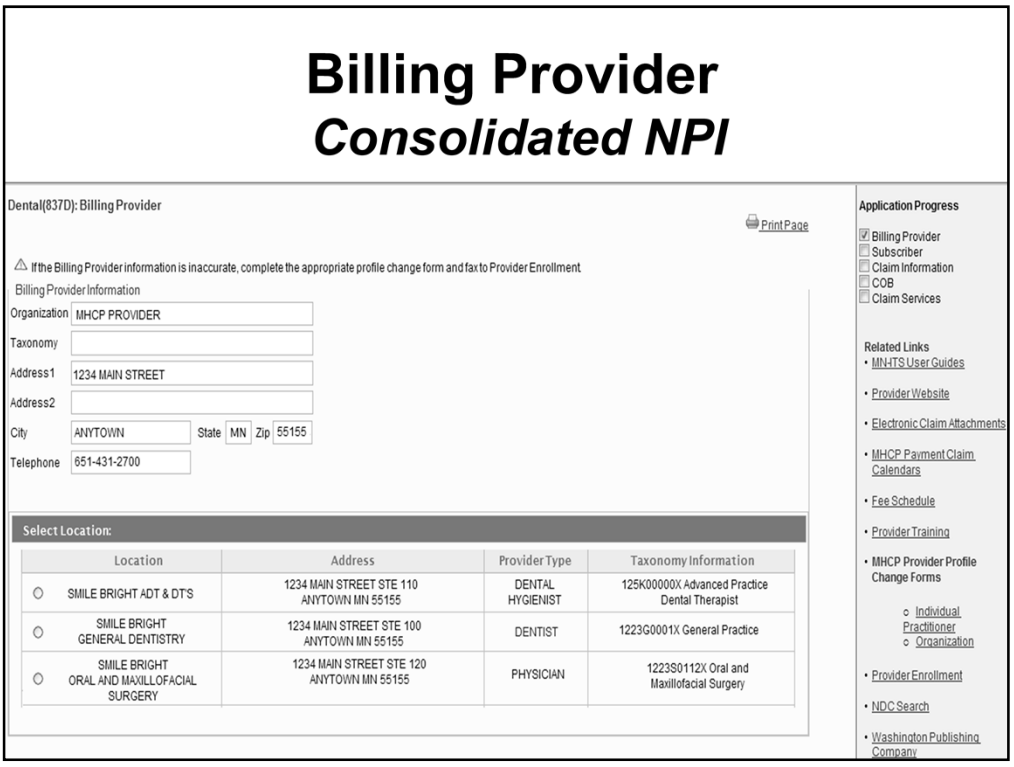
This brings us to the 837D Billing Provider screen, which is now the first of the new screens we will see.

The billing provider information will auto-populate with information from the MHCP provider record on file for the NPI that is used to login to MN–ITS.

Providers can no longer change the billing provider information. If you need to identify a different pay-to provider, you will be able to do that on the claim information screen in the other providers section.

All other provider types such as rendering, referring, service facility location or an assistant surgeon can be identified on the claim information screen in the other providers section or on the Services screen in the other providers section.

Billing Provider
Consolidated NPI

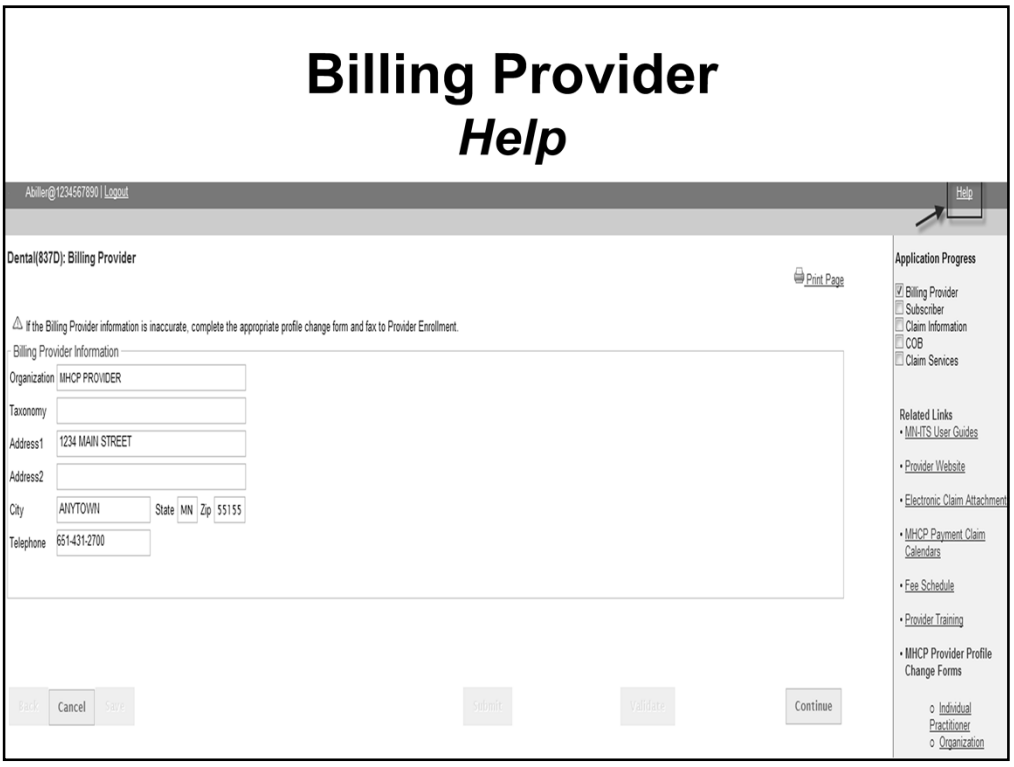


Providers who have one NPI for multiple locations are known as consolidated providers. Each location that is associated with the NPI used to login to MN–ITS will display with each locations name, address, provider type and any associated Taxonomy information that provider has on file with MHCP in a table format.

Not all consolidated providers need a taxonomy code. Only those where the 9 digit zip-code are the same.

Consolidated providers must select the radio button next to the location that is associated with their claim. Once selected the Billing Provider Information will auto-populate with that locations address and taxonomy information into the billing provider information fields.

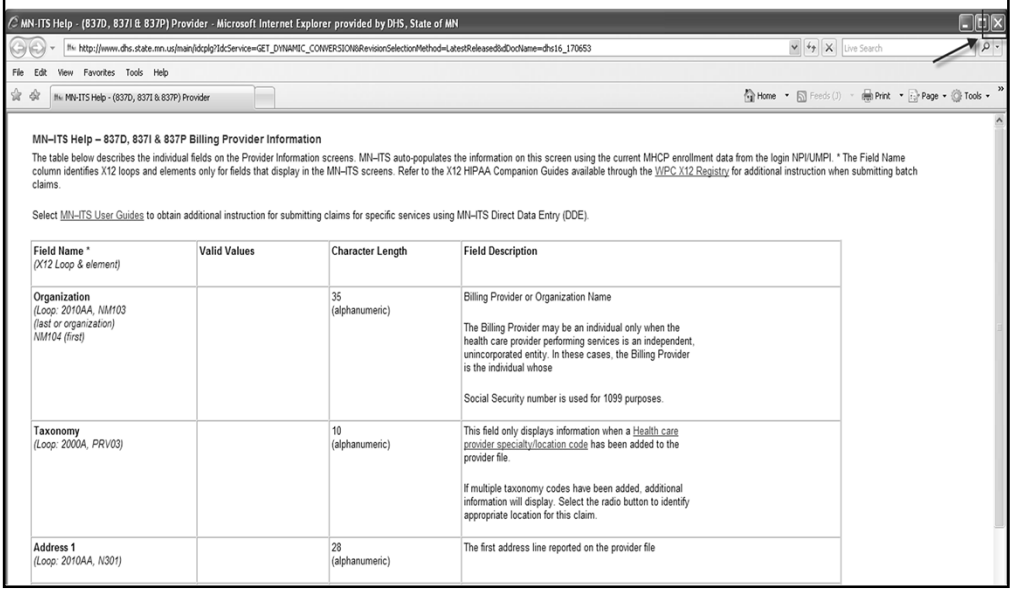
Billing Provider
Help



In the upper right we have a Help link that provides an overview of all fields on the current screen. As you move through the screens, the help link when selected with display field information specific to the screen you are on.

Select the **Help** link to open the Billing Provider field help information.

Billing Provider
Help Pop-up


MN-ITS Help - (837D, 837I & 837P) Provider - Microsoft Internet Explorer provided by DHS, State of MN
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_170653
File Edit View Favorites Tools Help
MN-ITS Help - (837D, 837I & 837P) Provider
Home Feeds (J) Print Page Tools
MN–ITS Help – 837D, 837I & 837P Billing Provider Information
The table below describes the individual fields on the Provider Information screens. MN–ITS auto-populates the information on this screen using the current MHCP enrollment data from the login NPI/UMPI. * The Field Name column identifies X12 loops and elements only for fields that display in the MN–ITS screens. Refer to the X12 HIPAA Companion Guides available through the WPC X12 Registry for additional instruction when submitting batch claims.
Select MN–ITS User Guides to obtain additional instruction for submitting claims for specific services using MN–ITS Direct Data Entry (DDE).
Field Name * (X12 Loop & element)
Valid Values
Character Length
Field Description
Organization (Loop: 2010AA, NM103 (last or organization) NM104 (first))
35 (alphanumeric)
Billing Provider or Organization Name
The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity. In these cases, the Billing Provider is the individual whose
Social Security number is used for 1099 purposes.
Taxonomy (Loop: 2000A, PRV03)
10 (alphanumeric)
This field only displays information when a Health care provider specialty/location code has been added to the provider file.
If multiple taxonomy codes have been added, additional information will display. Select the radio button to identify appropriate location for this claim.
Address 1 (Loop: 2010AA, N301)
28 (alphanumeric)
The first address line reported on the provider file

The Billing Provider help information is displayed in a separate pop-up window as a table format.

The first column is the field name which identifies the name of the field and the electronic X12 loop and element associated to the field.

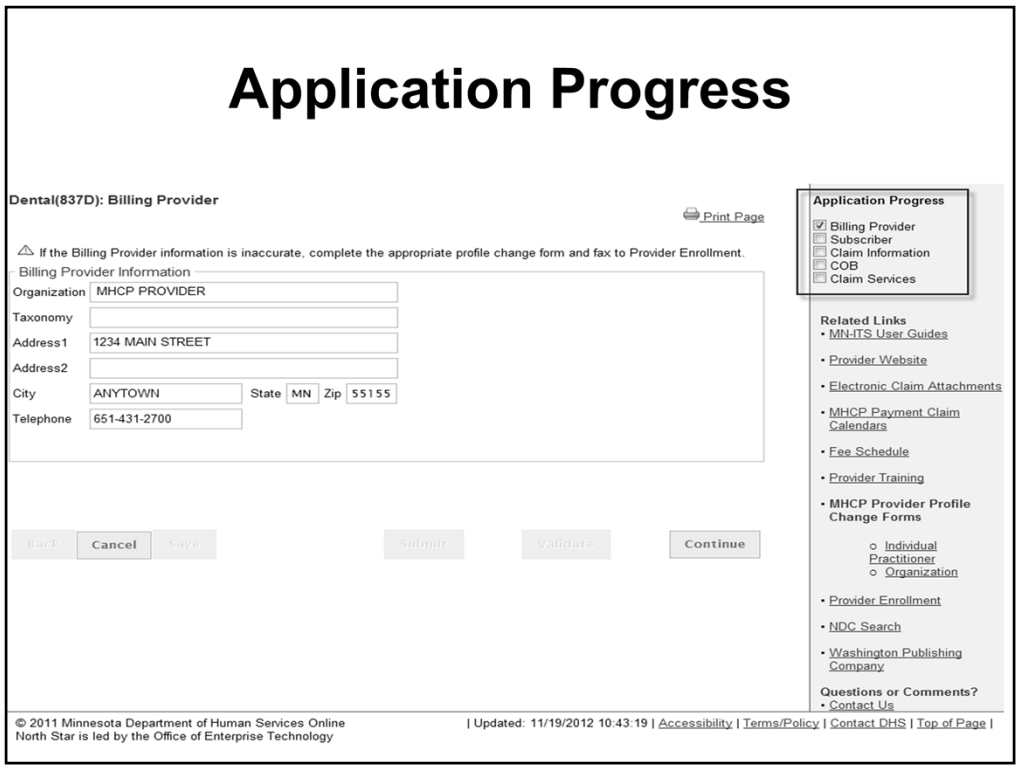
The next column Valid Values provides the X12 format used in the field.

Next is Character Length lists the maximum number of allowed characters that may be entered.

The last column is Field Description provides a description of what the fields purpose.

For additional instruction on completing fields for a specific service, refer to the MN-ITS User Guides link at the top.

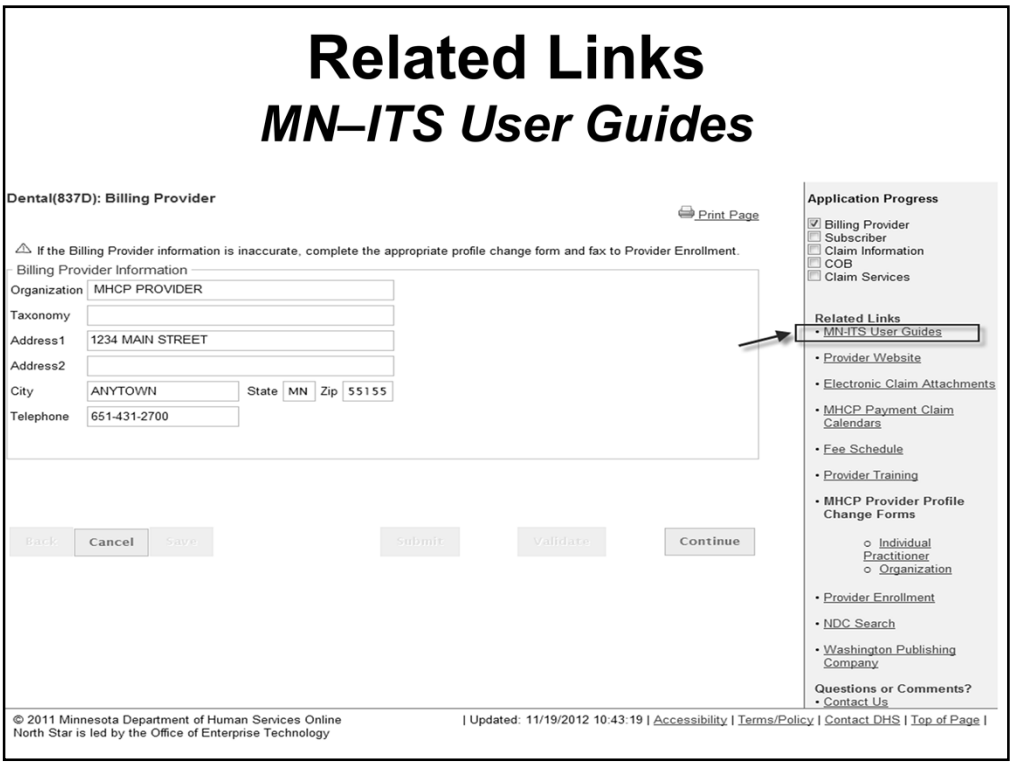
Select the **X** in the right hand corner to close the help screen.



The Application Progress feature to the upper right is new. It displays which screens have been completed and will help you navigate from screen to screen. We'll discuss this more as we navigate through the claim screens.

Additional links on the right navigation menu under **Related Links;** provides you with additional information you may need while entering a claim.

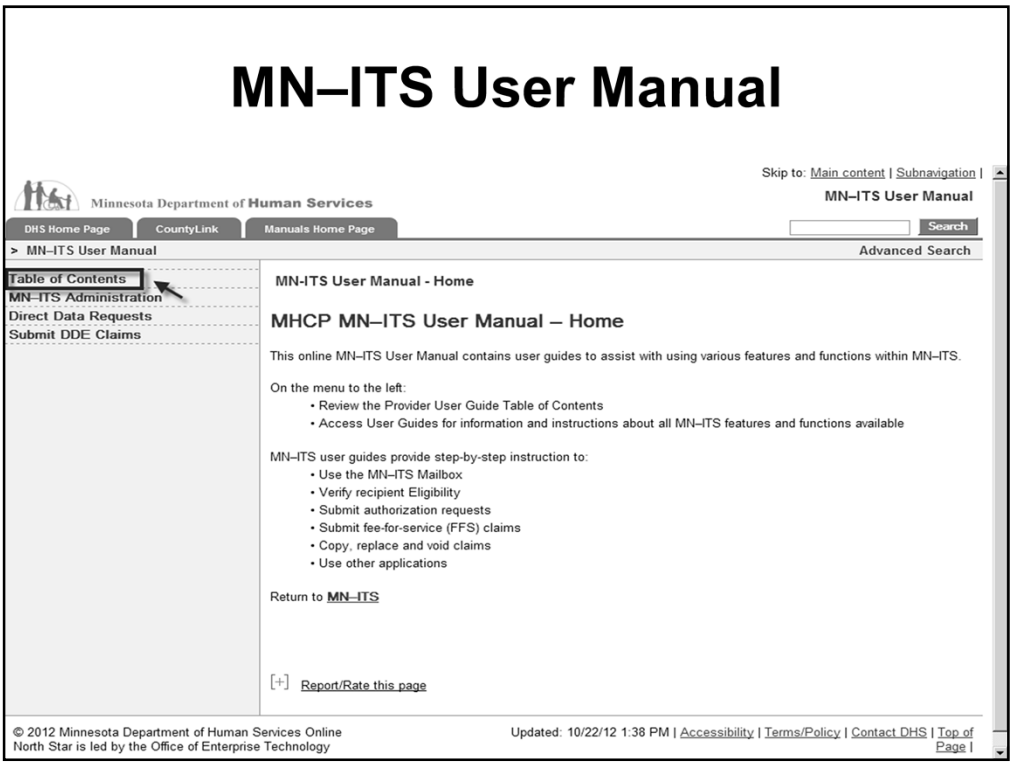
Related Links
MN–ITS User Guides



The first related link is MN-ITS User Guides. Our new MN-ITS User Manual Webpage is where the User Guides will be available for providers to access. As a result of the claim screen changes, the user guides also needed updating.

You may want to access a specific user guide while in the new claim transaction, especially when using the new screens for the first few times.

Select **MN–ITS User Guides**.


MN–ITS User Manual
Skip to: Main content | Subnavigation |
Minnesota Department of Human Services
MN–ITS User Manual
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CountyLink
Manuals Home Page
Search
> MN–ITS User Manual
Advanced Search
Table of Contents
MN–ITS Administration
Direct Data Requests
Submit DDE Claims
MN-ITS User Manual - Home
MHCP MN–ITS User Manual – Home
This online MN–ITS User Manual contains user guides to assist with using various features and functions within MN–ITS.
On the menu to the left:
• Review the Provider User Guide Table of Contents
• Access User Guides for information and instructions about all MN–ITS features and functions available
MN–ITS user guides provide step-by-step instruction to:
• Use the MN–ITS Mailbox
• Verify recipient Eligibility
• Submit authorization requests
• Submit fee-for-service (FFS) claims
• Copy, replace and void claims
• Use other applications
Return to MN–ITS
Report/Rate this page
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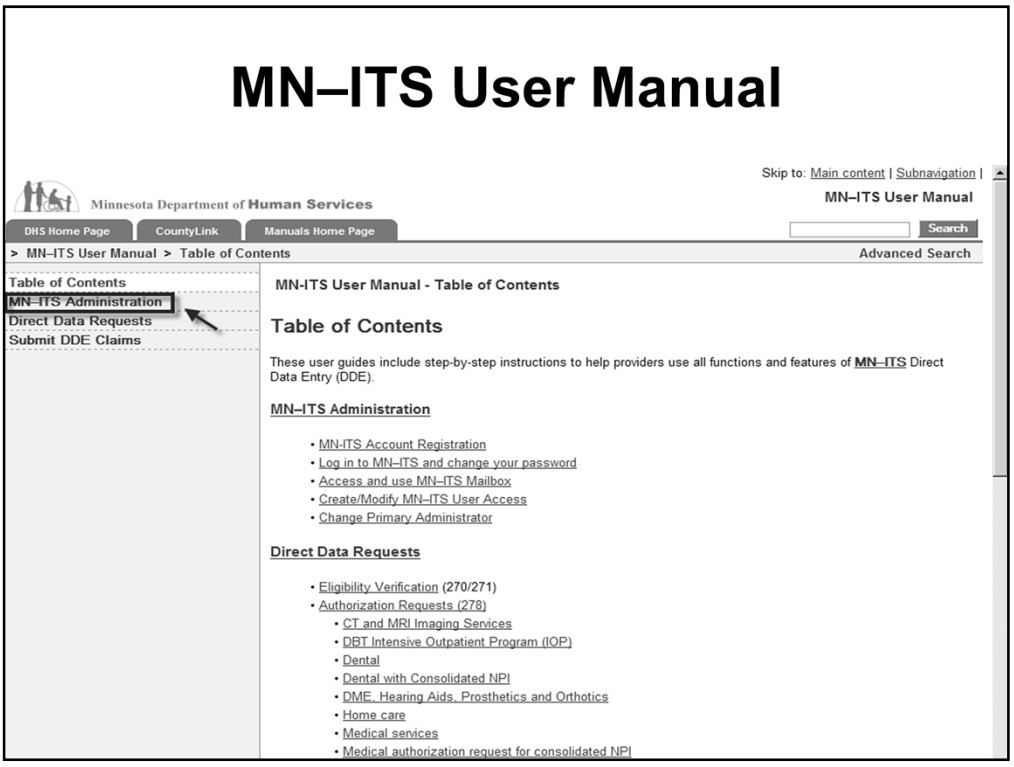
Updated: 10/22/12 1:38 PM | Accessibility | Terms/Policy | Contact DHS | Top of Page |

First, from the left side navigation menu select **Table of Contents**.


MN–ITS User Manual
Skip to: Main content | Subnavigation |
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DHS Home Page
CountyLink
Manuals Home Page
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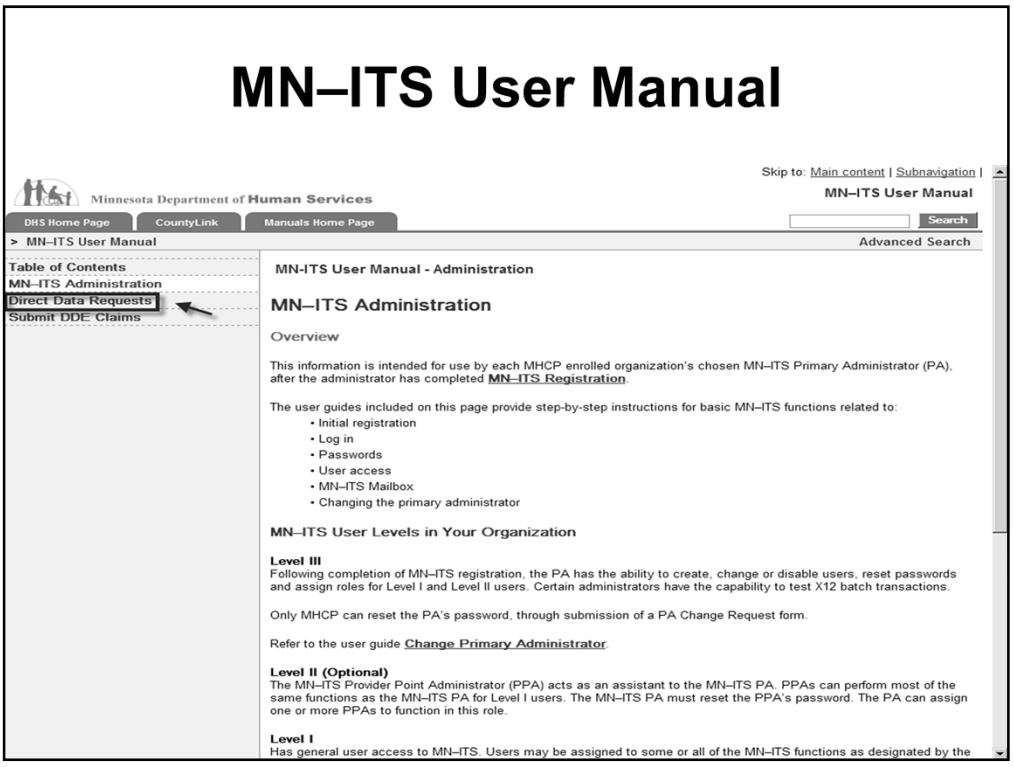
> MN–ITS User Manual > Table of Contents
Advanced Search
Table of Contents
MN–ITS Administration
Direct Data Requests
Submit DDE Claims
MN-ITS User Manual - Table of Contents
Table of Contents
These user guides include step-by-step instructions to help providers use all functions and features of MN–ITS Direct Data Entry (DDE).
MN–ITS Administration
• MN-ITS Account Registration
• Log in to MN–ITS and change your password
• Access and use MN–ITS Mailbox
• Create/Modify MN–ITS User Access
• Change Primary Administrator
Direct Data Requests
• Eligibility Verification (270/271)
• Authorization Requests (278)
• CT and MRI Imaging Services
• DBT Intensive Outpatient Program (IOP)
• Dental
• Dental with Consolidated NPI
• DME, Hearing Aids, Prosthetics and Orthotics
• Home care
• Medical services
• Medical authorization request for consolidated NPI

The Table of Contents lists in the center section all of the user guides that are available . The user guides are grouped under the different heading options; which also appear in the left navigation menu.

Next, from the left navigation menu select **MN-ITS Administration**.


MN–ITS User Manual
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Direct Data Requests
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MN-ITS User Manual - Administration
MN–ITS Administration
Overview
This information is intended for use by each MHCP enrolled organization's chosen MN–ITS Primary Administrator (PA), after the administrator has completed MN–ITS Registration.
The user guides included on this page provide step-by-step instructions for basic MN–ITS functions related to:
• Initial registration
• Log in
• Passwords
• User access
• MN–ITS Mailbox
• Changing the primary administrator
MN–ITS User Levels in Your Organization
Level III
Following completion of MN–ITS registration, the PA has the ability to create, change or disable users, reset passwords and assign roles for Level I and Level II users. Certain administrators have the capability to test X12 batch transactions.
Only MHCP can reset the PA's password, through submission of a PA Change Request form.
Refer to the user guide Change Primary Administrator.
Level II (Optional)
The MN–ITS Provider Point Administrator (PPA) acts as an assistant to the MN–ITS PA. PPAs can perform most of the same functions as the MN–ITS PA for Level I users. The MN–ITS PA must reset the PPA's password. The PA can assign one or more PPAs to function in this role.
Level I
Has general user access to MN–ITS. Users may be assigned to some or all of the MN–ITS functions as designated by the

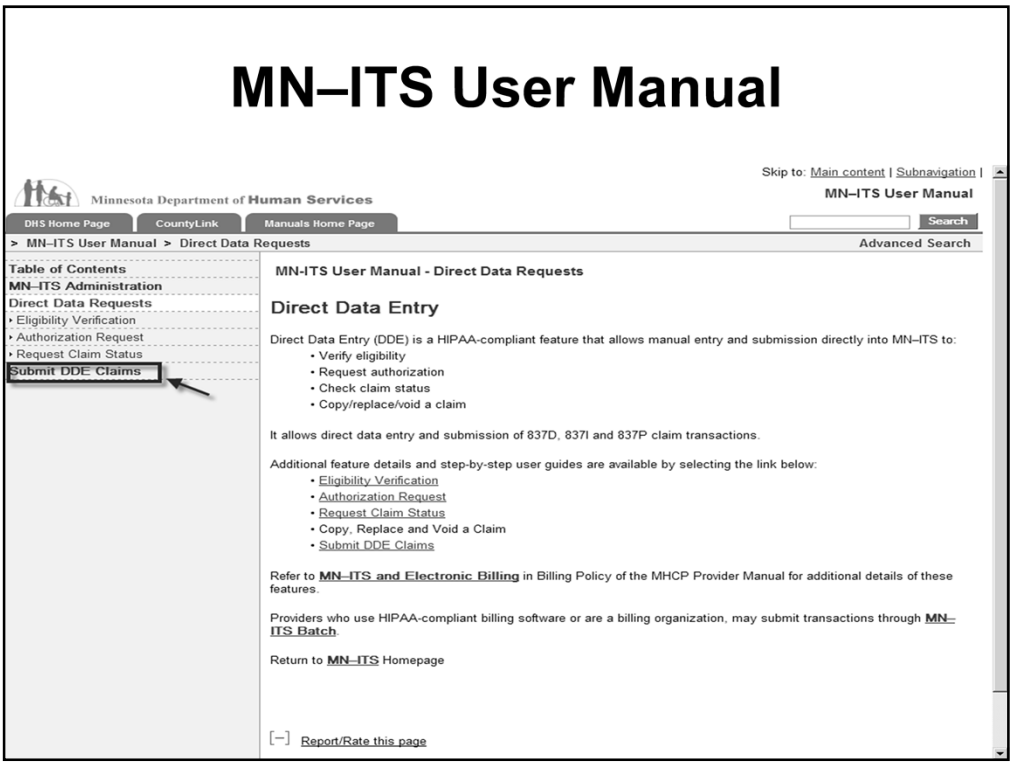
The MN-ITS Administration page contains an overview of information intended for your organization's MN-ITS Primary Administrator such as:

- User levels within a providers MN-ITS account, and each of their roles and responsibilities
- MN–ITS Registration User Guide

Once registered the MN-ITS Primary Administrator or a Secondary administrators can use this page to find User Guides on how to:

- Create and assign access to new users
- Reset passwords for users
- And disable users who no longer need access, or have left your office

Next from the left navigation menu select **Direct Data Requests**.


MN–ITS User Manual
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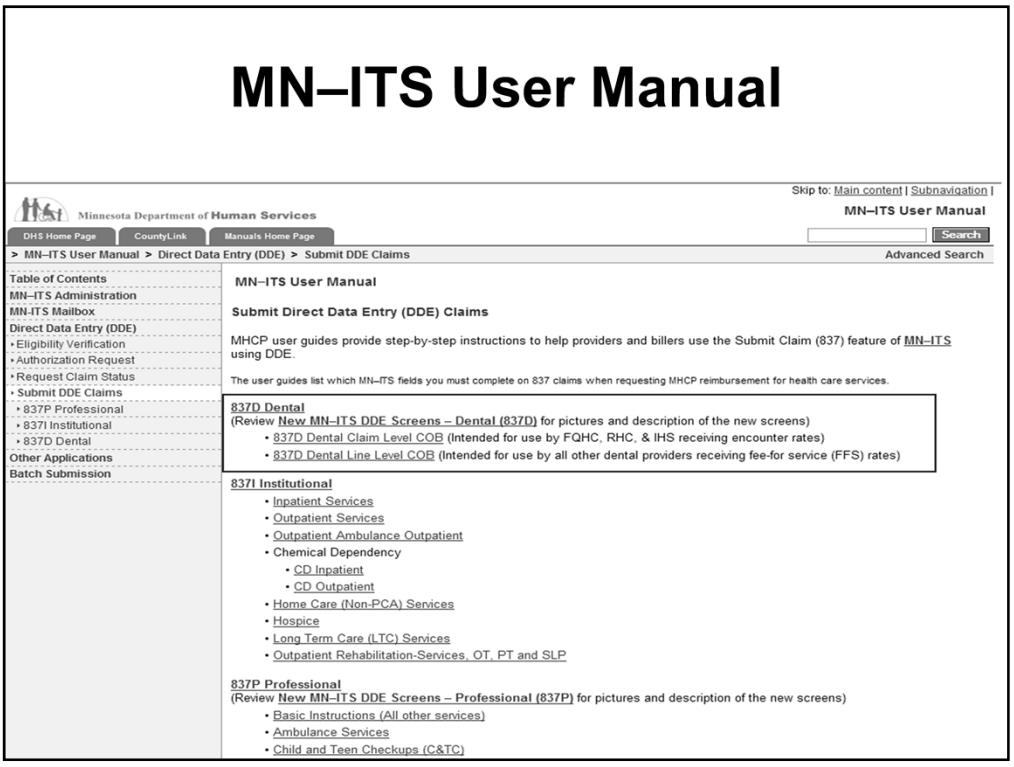
MN–ITS Administration
Direct Data Requests
Eligibility Verification
Authorization Request
Request Claim Status
Submit DDE Claims
MN-ITS User Manual - Direct Data Requests
Direct Data Entry
Direct Data Entry (DDE) is a HIPAA-compliant feature that allows manual entry and submission directly into MN–ITS to:
• Verify eligibility
• Request authorization
• Check claim status
• Copy/replace/void a claim
It allows direct data entry and submission of 837D, 837I and 837P claim transactions.
Additional feature details and step-by-step user guides are available by selecting the link below:
• Eligibility Verification
• Authorization Request
• Request Claim Status
• Copy, Replace and Void a Claim
• Submit DDE Claims
Refer to MN–ITS and Electronic Billing in Billing Policy of the MHCP Provider Manual for additional details of these features.
Providers who use HIPAA-compliant billing software or are a billing organization, may submit transactions through MN–ITS Batch.
Return to MN–ITS Homepage
[–] Report/Rate this page

The Direct Data Requests Web page contains links to the following user guides:

- Verifying eligibility
- Submitting requests for authorization
- Requesting claim status
- Using the Copy/replace/void claim features
- Submitting DDE Claims

From the left navigation menu select **Submit DDE Claims**.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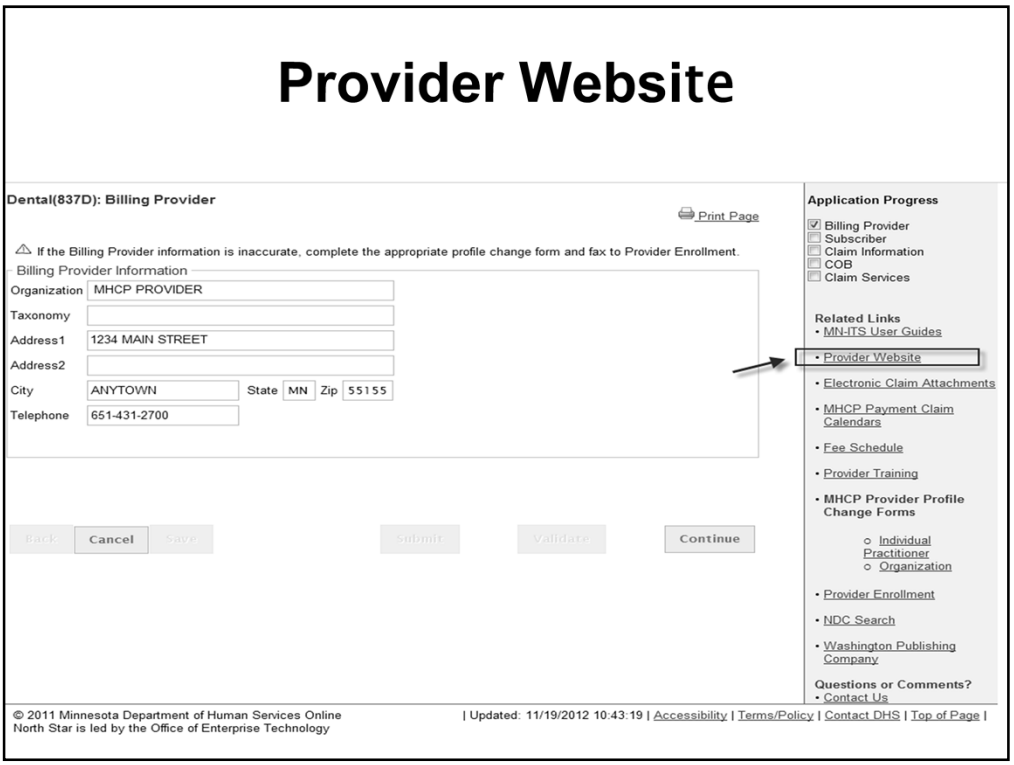
• Request Claim Status
• Submit DDE Claims
• 837P Professional
• 837I Institutional
• 837D Dental
Other Applications
Batch Submission
MN–ITS User Manual
Submit Direct Data Entry (DDE) Claims
MHCP user guides provide step-by-step instructions to help providers and billers use the Submit Claim (837) feature of MN–ITS using DDE.
The user guides list which MN–ITS fields you must complete on 837 claims when requesting MHCP reimbursement for health care services.
837D Dental
(Review New MN–ITS DDE Screens – Dental (837D) for pictures and description of the new screens)
• 837D Dental Claim Level COB (Intended for use by FQHC, RHC, & IHS receiving encounter rates)
• 837D Dental Line Level COB (Intended for use by all other dental providers receiving fee-for service (FFS) rates)
837I Institutional
• Inpatient Services
• Outpatient Services
• Outpatient Ambulance Outpatient
• Chemical Dependency
• CD Inpatient
• CD Outpatient
• Home Care (Non-PCA) Services
• Hospice
• Long Term Care (LTC) Services
• Outpatient Rehabilitation-Services, OT, PT and SLP
837P Professional
(Review New MN–ITS DDE Screens – Professional (837P) for pictures and description of the new screens)
• Basic Instructions (All other services)
• Ambulance Services
• Child and Teen Checkups (C&TC)

*If you are reviewing your training materials for this webinar, this screen has been updated, but the process to get here has not changed.

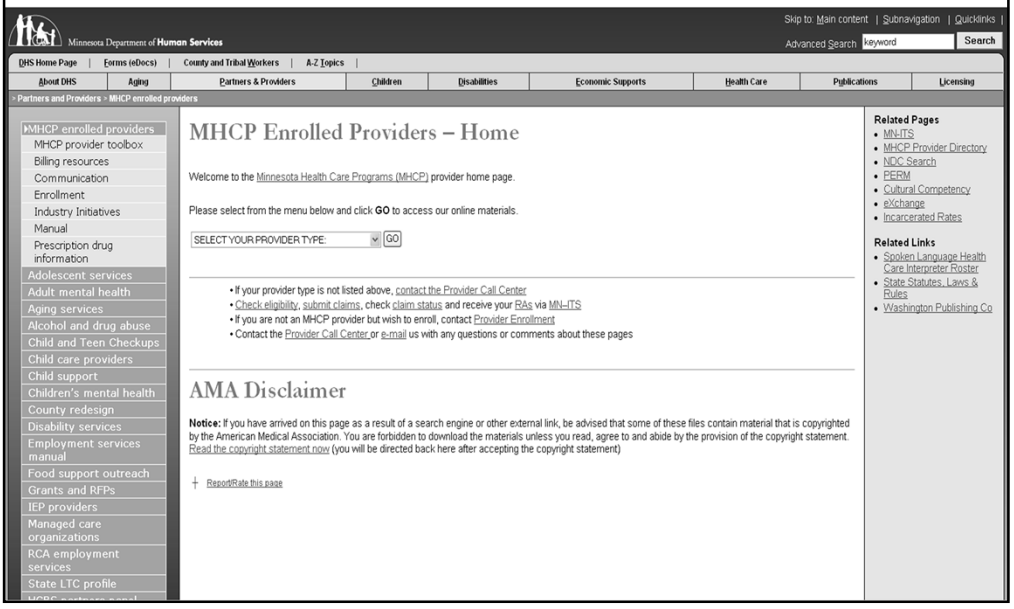
On the left navigation menu under Submit DDE Claims subsections will display for each type of grouped User Guides.

In the center section these groups will list the individual user guides that are associated to that specific group. For example, under 837D Dental providers can view the actual screen shots for the dental claim, and are able to access the step-by-step instructions for submitting claims using the MN–ITS 837D Line Level COB user guide.



Next in the right navigation menu under Related Links the **Provider Website** link takes us to the MHCP Enrolled Provider Website.

MHCP Provider Website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MHCP Enrolled Providers – Home
Welcome to the Minnesota Health Care Programs (MHCP) provider home page.
Please select from the menu below and click GO to access our online materials.
SELECT YOUR PROVIDER TYPE:
GO
• If your provider type is not listed above, contact the Provider Call Center
• Check eligibility, submit claims, check claim status and receive your RAs via MN-ITS
• If you are not an MHCP provider but wish to enroll, contact Provider Enrollment
• Contact the Provider Call Center or e-mail us with any questions or comments about these pages
AMA Disclaimer
Notice: If you have arrived on this page as a result of a search engine or other external link, be advised that some of these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the materials unless you read, agree to and abide by the provision of the copyright statement. Read the copyright statement now (you will be directed back here after accepting the copyright statement)
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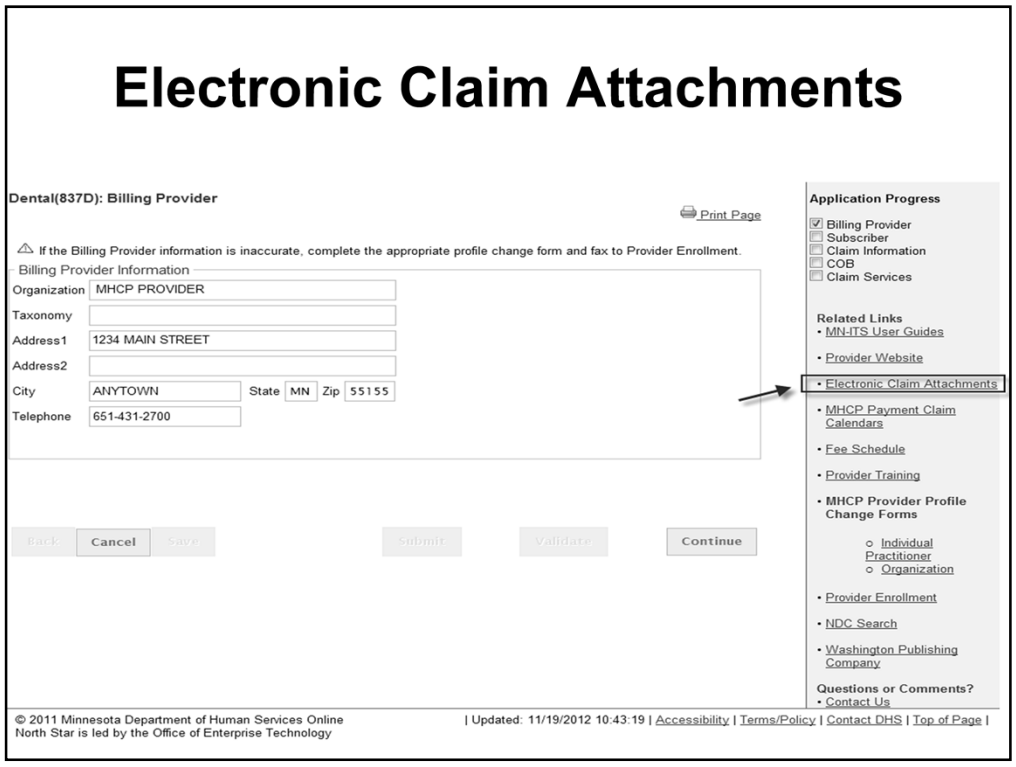
Washington Publishing Co

From the home page you can access MHCP **Billing resources**, **Communications**; such as our Provider News Messages and Provider Updates.

It also provides information on **Industry Initiatives** that impact providers; such as provider incentives for those dentists that meet the electronic health record requirements. By selecting **Manual** you will be directed to the MHCP Manual where providers can access our dental policy and dental authorization information.

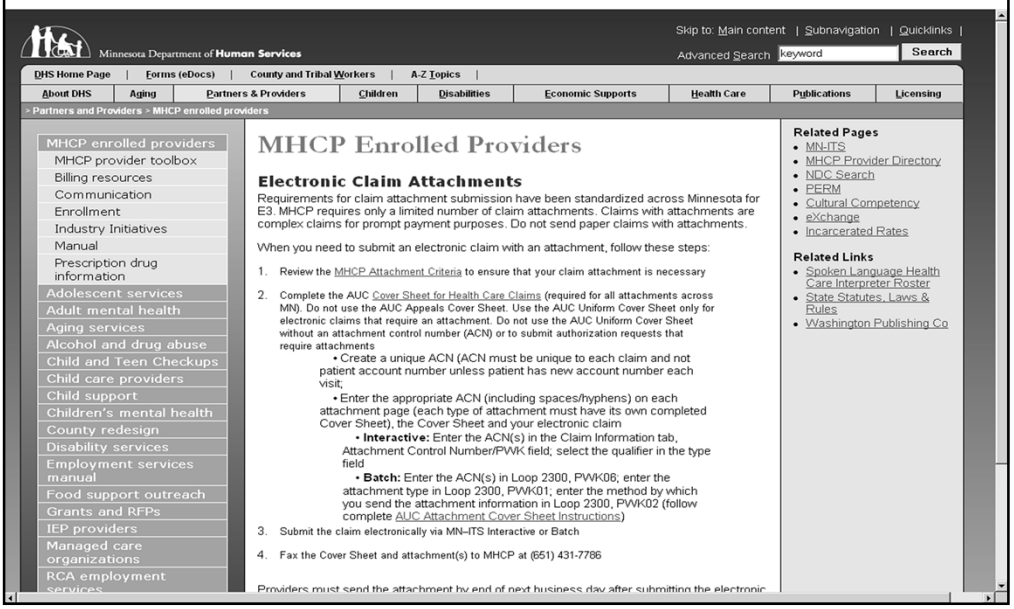
From the center section providers can also access provider specific information by selecting the drop-down arrow, selecting Dental Providers and then select the go button to be directed to the Dental Providers provider specific Webpage.

Electronic Claim Attachments



From the right navigation menu select the **Electronic Claim Attachment** link for those claims that requires additional supporting documentation be faxed and connected electronically to your claim submission.

Electronic Claim Attachments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MHCP Enrolled Providers
Electronic Claim Attachments
Requirements for claim attachment submission have been standardized across Minnesota for E3. MHCP requires only a limited number of claim attachments. Claims with attachments are complex claims for prompt payment purposes. Do not send paper claims with attachments.
When you need to submit an electronic claim with an attachment, follow these steps:
1. Review the MHCP Attachment Criteria to ensure that your claim attachment is necessary
2. Complete the AUC Cover Sheet for Health Care Claims (required for all attachments across MN). Do not use the AUC Appeals Cover Sheet. Use the AUC Uniform Cover Sheet only for electronic claims that require an attachment. Do not use the AUC Uniform Cover Sheet without an attachment control number (ACN) or to submit authorization requests that require attachments
• Create a unique ACN (ACN must be unique to each claim and not patient account number unless patient has new account number each visit;
• Enter the appropriate ACN (including spaces/hyphens) on each attachment page (each type of attachment must have its own completed Cover Sheet), the Cover Sheet and your electronic claim
• Interactive: Enter the ACN(s) in the Claim Information tab, Attachment Control Number/PWK field; select the qualifier in the type field
• Batch: Enter the ACN(s) in Loop 2300, PWK06; enter the attachment type in Loop 2300, PWK01; enter the method by which you send the attachment information in Loop 2300, PWK02 (follow complete AUC Attachment Cover Sheet Instructions)
3. Submit the claim electronically via MN–ITS Interactive or Batch
4. Fax the Cover Sheet and attachment(s) to MHCP at (651) 431-7786
Providers must send the attachment by end of next business day after submitting the electronic
Related Pages
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eXchange
Incarcerated Rates
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State Statutes, Laws & Rules
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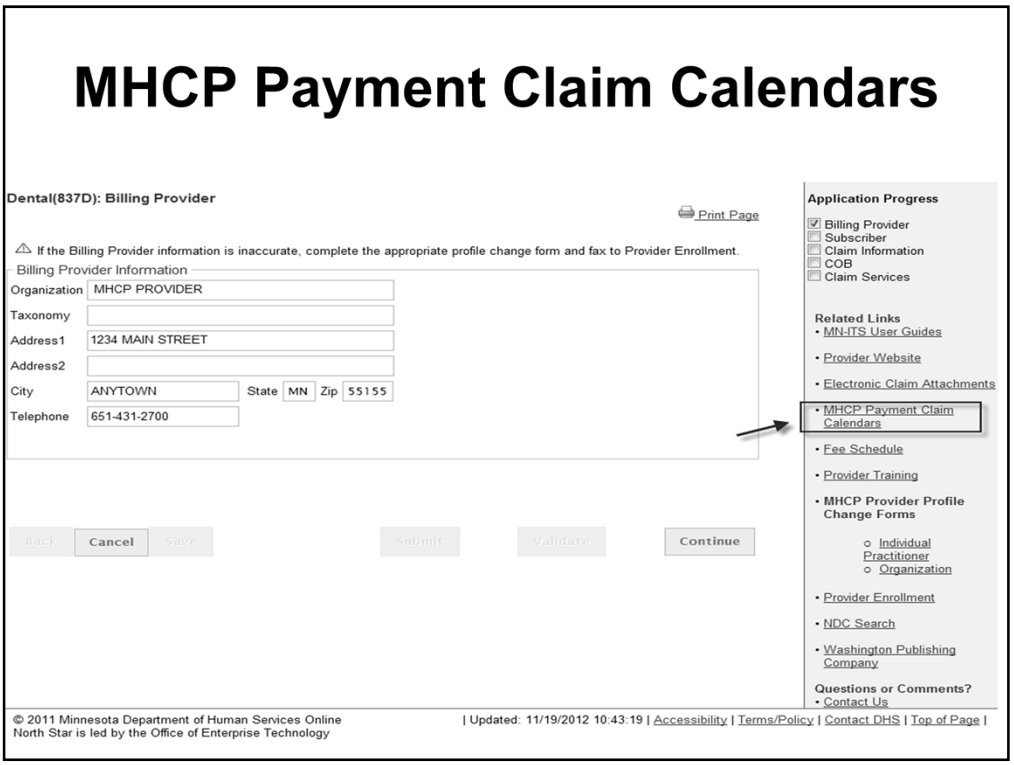
To submit claims with attachments, this Web page provides you with links to:

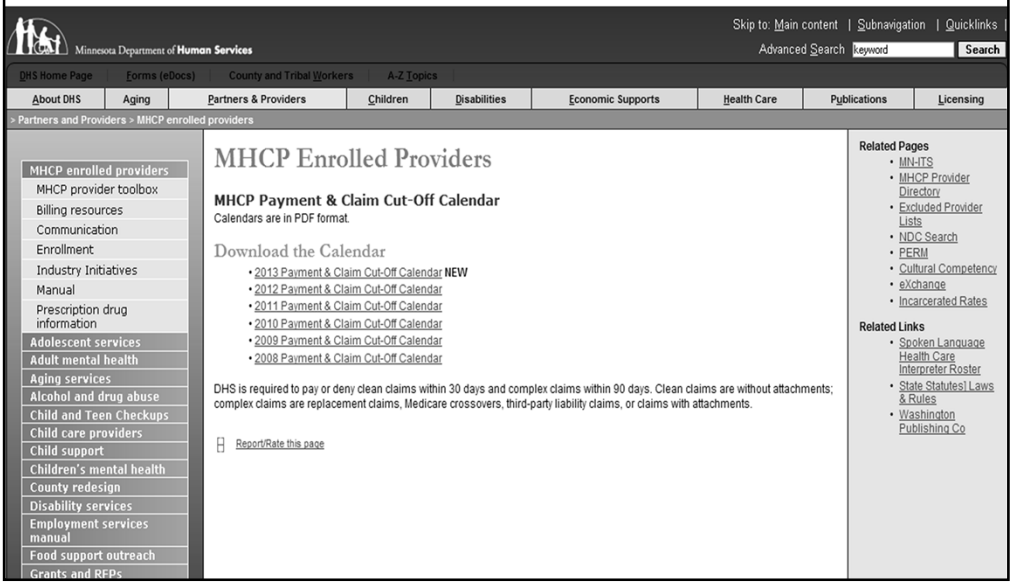
- MHCP Attachment Criteria for submitting claims with attachments
- The required AUC Uniform Cover Sheet for Health Care Claim Attachments, which includes the MN Dept. of Human Services Fax number (651-431-7786)
- And instructions on how to complete and submit the Attachment

Remember that your electronic claim and the AUC cover sheet must both have the same identifiers in order for MCHP to accurately process your claim. If the billing providers NPI, Attachment Claim Number or the recipients Subscriber ID are missing or different; no match will be found and your claim will deny.



Next on the right navigation menu the **MHCP Payment Claim Calendars** link allows providers to access the claim payment and cut-off date calendars.

MHCP Payment Claim Calendars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MHCP Payment & Claim Cut-Off Calendar
Calendars are in PDF format.
Download the Calendar
• 2013 Payment & Claim Cut-Off Calendar NEW
• 2012 Payment & Claim Cut-Off Calendar
• 2011 Payment & Claim Cut-Off Calendar
• 2010 Payment & Claim Cut-Off Calendar
• 2009 Payment & Claim Cut-Off Calendar
• 2008 Payment & Claim Cut-Off Calendar
DHS is required to pay or deny clean claims within 30 days and complex claims within 90 days. Clean claims are without attachments; complex claims are replacement claims, Medicare crossovers, third-party liability claims, or claims with attachments.
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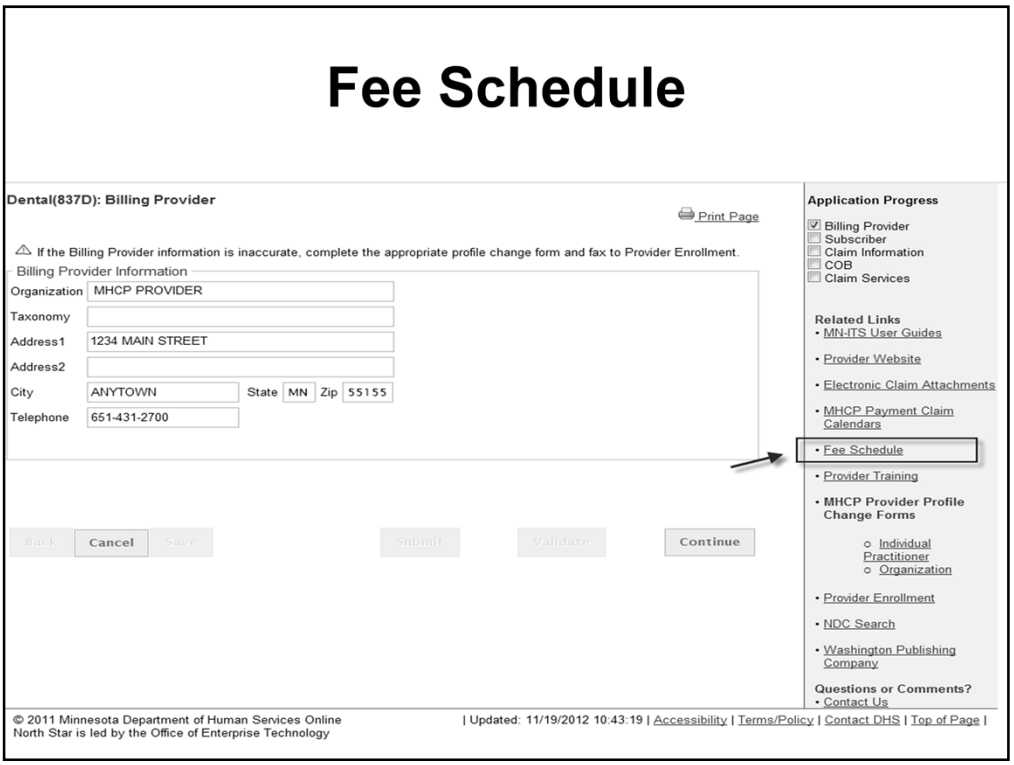
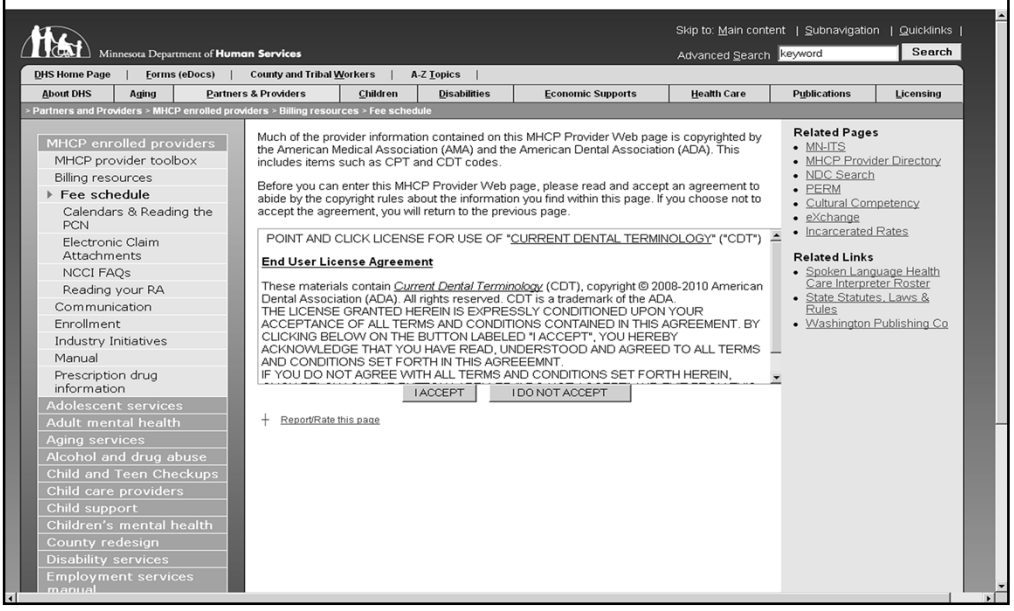
The Webpage contains calendars for the current year and also several years past. As well as links on how to read the payer claim number (PCN) and use the Julian calendars to verify the date the claim was received by MHCP.

Providers may find it helpful to know the claim cutoff date to ensure you are able to submit claims; and receive an acknowledgement during the current remittance advice cycle. We suggest providers bill early and often, don't wait to bill on the cutoff date.



From the right navigation menu the next link accesses the **Fee Schedule** for MHCP Fee-for-service recipients.

Fee Schedule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Much of the provider information contained on this MHCP Provider Web page is copyrighted by the American Medical Association (AMA) and the American Dental Association (ADA). This includes items such as CPT and CDT codes.
Before you can enter this MHCP Provider Web page, please read and accept an agreement to abide by the copyright rules about the information you find within this page. If you choose not to accept the agreement, you will return to the previous page.
POINT AND CLICK LICENSE FOR USE OF "CURRENT DENTAL TERMINOLOGY" ("CDT")
End User License Agreement
These materials contain Current Dental Terminology (CDT), copyright © 2008-2010 American Dental Association (ADA). All rights reserved. CDT is a trademark of the ADA.
THE LICENSE GRANTED HEREIN IS EXPRESSLY CONDITIONED UPON YOUR ACCEPTANCE OF ALL TERMS AND CONDITIONS CONTAINED IN THIS AGREEMENT. BY CLICKING BELOW ON THE BUTTON LABELED "I ACCEPT", YOU HEREBY ACKNOWLEDGE THAT YOU HAVE READ, UNDERSTOOD AND AGREED TO ALL TERMS AND CONDITIONS SET FORTH IN THIS AGREEEMNT.
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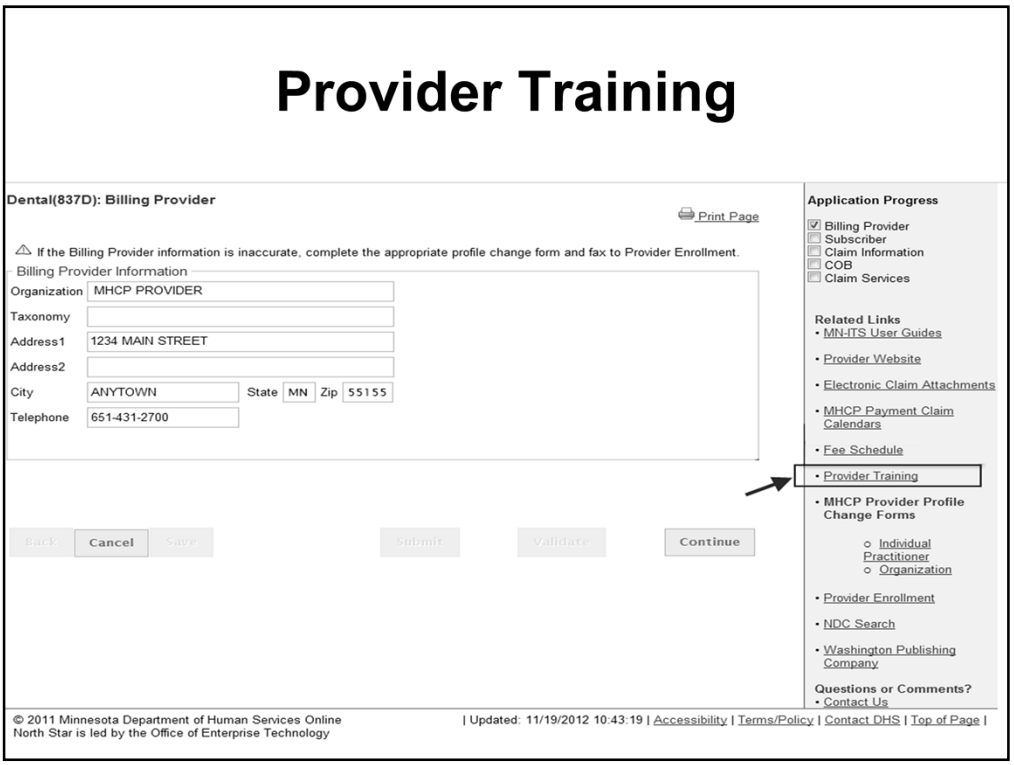
A Point and Click End User License Agreement will display. Once you have accepted the Point an Click License, you can use the fee schedule to locate the CDT code, and verify the MHCP total allowed amount for a service. Providers should submit their usual and customary charge for the services they render. This way MHCP will have a current value for the service to compare when reviewing rates.

Remember, legislative cutbacks and/or add-ons are not included in the total allowed amount that is displayed. The 3% payment rate reduction for dental services ended on June 30, 2013.

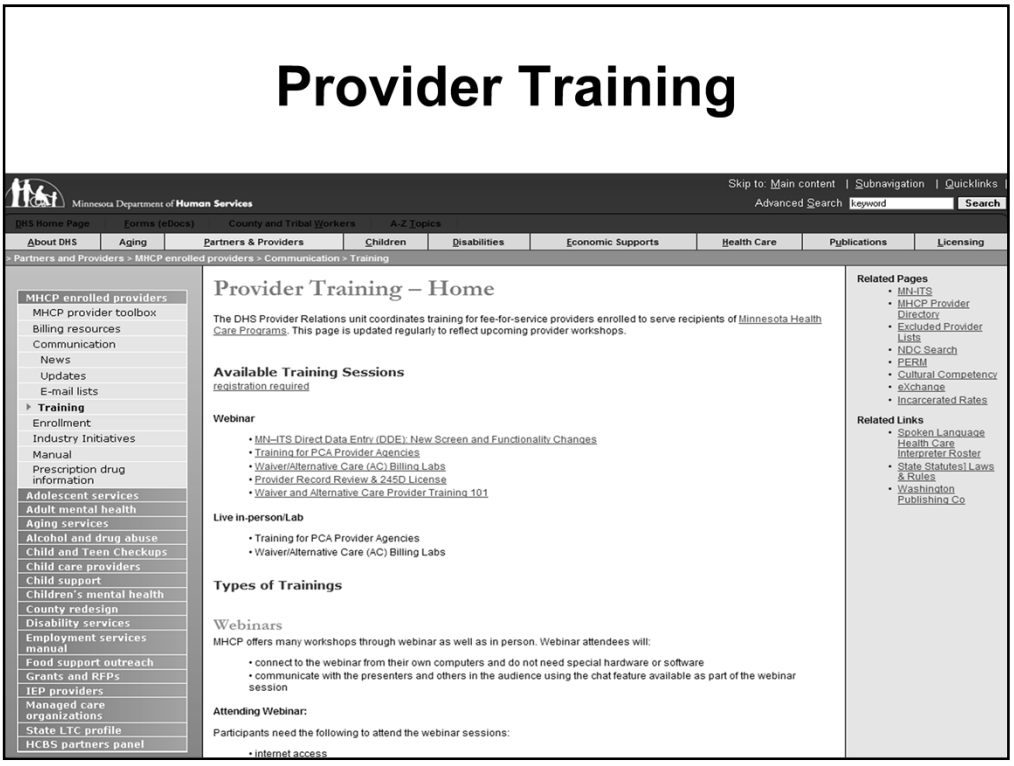
It's important to note that the fee schedule does not indicate if a procedure is not covered for the Non-pregnant adult population. Providers must review the MHCP Provider Manuals Dental Non-pregnant adult section for a list of eligible procedure codes. Codes that are not listed in the manuals Non-pregnant adult covered services section; means they are a non-covered service.

Providers must inform the recipient that a service is non-covered prior to preforming that service using the Advance Recipient Notice of Non-covered Service/Item, form number DHS-3640; which was mandated as of July 2012.



Next on the right navigation menu the **Provider Training** page brings you to a list of our available trainings.

Provider Training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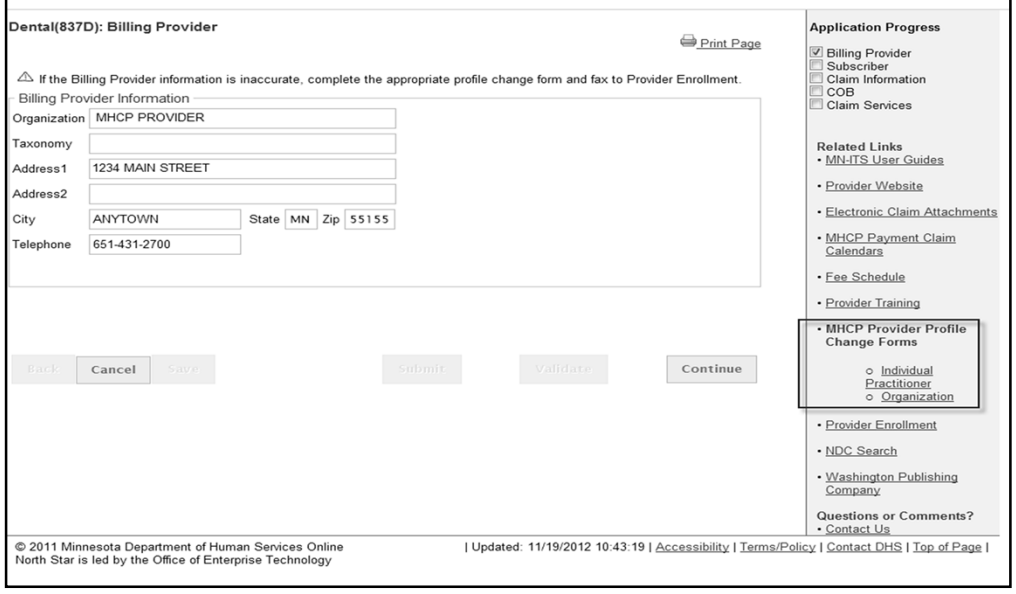
HCBS partners panel
Provider Training – Home
The DHS Provider Relations unit coordinates training for fee-for-service providers enrolled to serve recipients of Minnesota Health Care Programs. This page is updated regularly to reflect upcoming provider workshops.
Available Training Sessions
registration required
Webinar
• MN–ITS Direct Data Entry (DDE): New Screen and Functionality Changes
• Training for PCA Provider Agencies
• Waiver/Alternative Care (AC) Billing Labs
• Provider Record Review & 245D License
• Waiver and Alternative Care Provider Training 101
Live in-person/Lab
• Training for PCA Provider Agencies
• Waiver/Alternative Care (AC) Billing Labs
Types of Trainings
Webinars
MHCP offers many workshops through webinar as well as in person. Webinar attendees will:
• connect to the webinar from their own computers and do not need special hardware or software
• communicate with the presenters and others in the audience using the chat feature available as part of the webinar session
Attending Webinar:
Participants need the following to attend the webinar sessions:
• internet access
Related Pages
• MN-ITS
• MHCP Provider Directory
• Excluded Provider Lists
• NDC Search
• PERM
• Cultural Competency
• eXchange
• Incarcerated Rates
Related Links
• Spoken Language Health Care Interpreter Roster
• State Statutes| Laws & Rules
• Washington Publishing Co

In the center section you can view available MHCP training opportunities and online recorded basic Webinars that can help if you find yourself struggling with the submission of a claim or want additional information or a refresher.

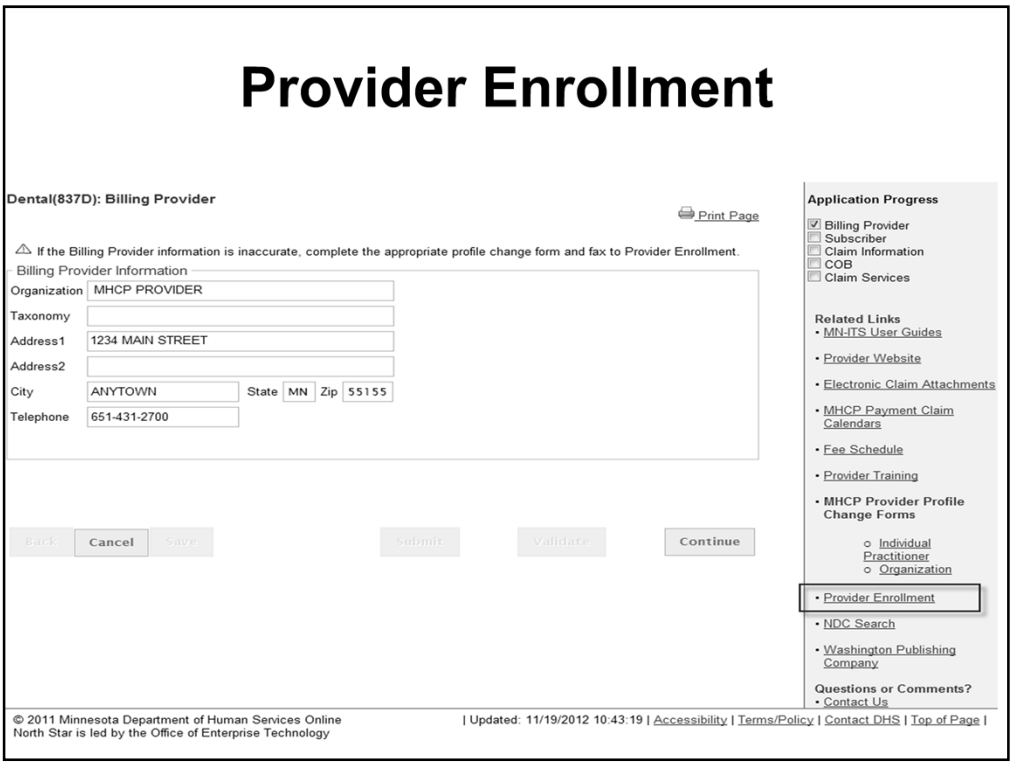
Look for Training Materials on the link **MN–ITS Direct Data Entry (DDE): New Screen and Functionality Changes.** Once on the webpage select the link titled **Training Materials.**

MHCP Provider Profile
Change Forms

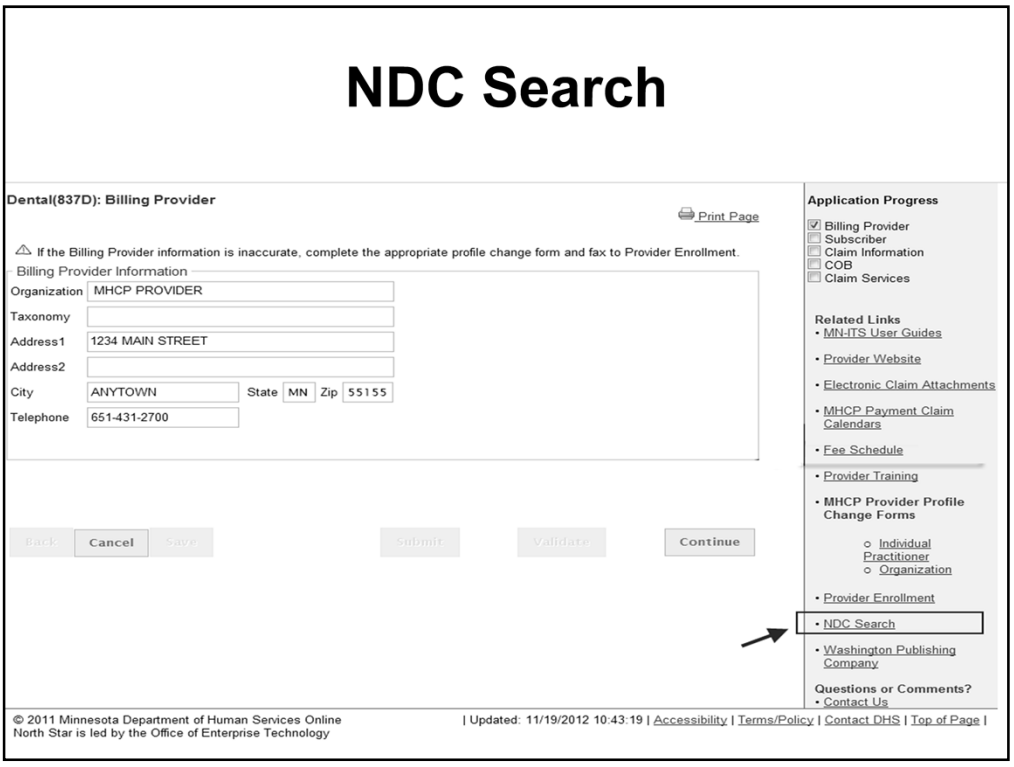


From the right navigation menu select the **MHCP Provider Profile Change Forms** link. These change forms are used to update your individual or organizational provider specific information. When the form has been completed and signed, fax the form to provider enrollment using the fax number listed on the form.

Completed change forms will be processed within 30 business days from the date they were received.

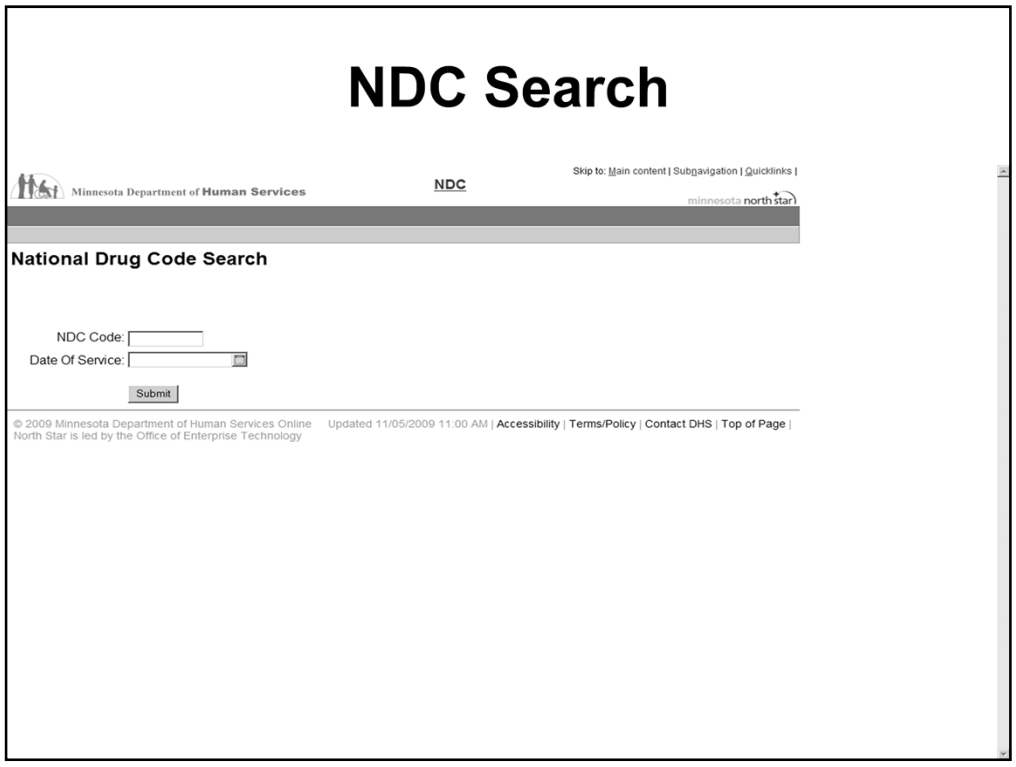


The **Provider Enrollment** page provides additional information about adding or changing your MHCP provider profile information or enrollment status.



Next on the right navigation menu **NDC Search** is intended for use by pharmacies and physicians who administer or prescribe drugs.

NDC Search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NDC
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minnesota north star
National Drug Code Search
NDC Code:
Date Of Service:
Submit
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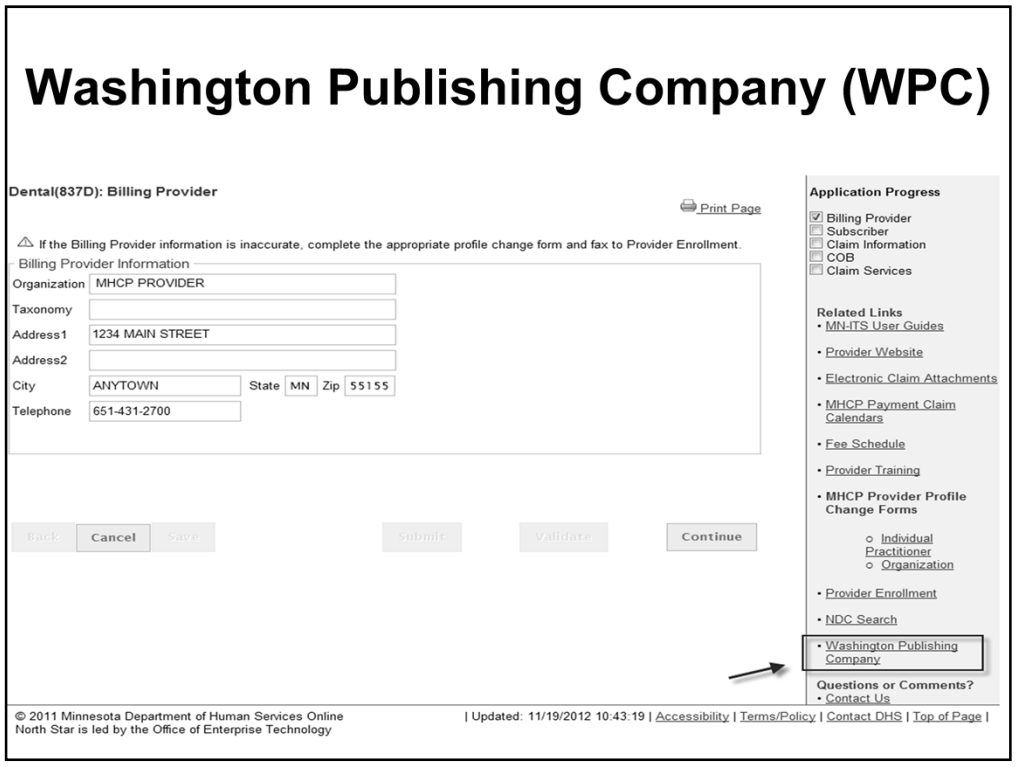
Updated 11/05/2009 11:00 AM | Accessibility | Terms/Policy | Contact DHS | Top of Page |

By entering the National Drug Code assigned to the medication and the date of service pharmacies and physicians can verify MHCP coverage information for that specific medication.



From the right navigation menu a link to the **Washington Publishing Company** HIPAA compliant code lists is now available from any screen during your claim submission. Select **Washington Publishing Company.**

WPC

WPC
Washington Publishing Company
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Reference
Contact
Reference
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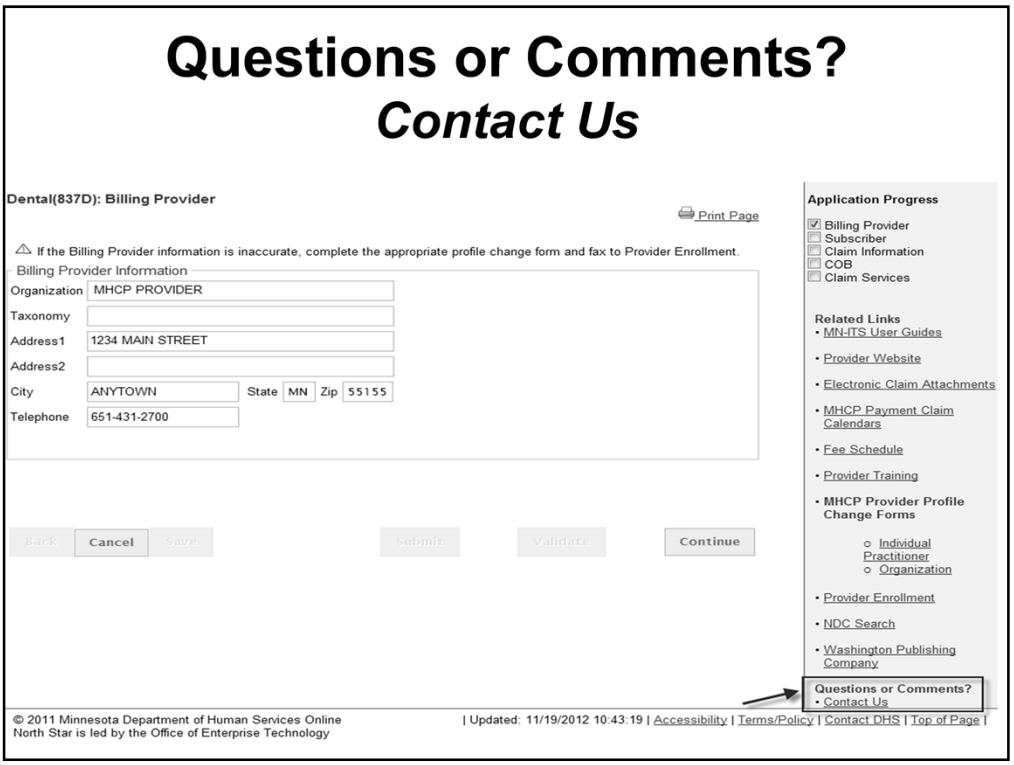
Sign In | My Cart | Checkout
Code Lists
ASC X12 assists several organizations in the maintenance and distribution of code lists external to the X12 family of standards. The lists are maintained by the Centers for Medicare and Medicaid Services (CMS), The National Uniform Claim Committee (NUCC), and committees that meet during standing X12 meetings.
Health Care Code Lists
> Claim Adjustment Reason Codes (CARC)
> Remittance Advice Remark Codes (RARC)
> Claim Status Category Codes
> Claim Status Codes
> Health Care Service Type Codes
> Health Care Services Decision Reason Codes
> Health Care Provider Taxonomy Code Set
> Provider Characteristics Codes
> Insurance Business Process Application Error Codes
Property & Casualty Code Lists
> Several EDI-Related Property & Casualty Code Lists
X12 Registry
A complete listing of every ASC X12 Implementation Guide (IG) and Technical Report Type 3 (TR3). Includes description, registration/publication dates, and contact information.
> X12 Registry
ASC X12N/TG4
ASC X12N's Task Group 4 is the Technical Report Task Group. TG4 maintains a collection of documents.
> ASC X12N/TG4 Document Repository
Code Lists for Purchase
Code Lists can be purchased as electronic CSV files, email change alert subscription, or printed lists.
It's the simple things that matter most.
Get the Medicare prescription drug coverage you need, the benefits you want and the savings you deserve.
LEARN MORE

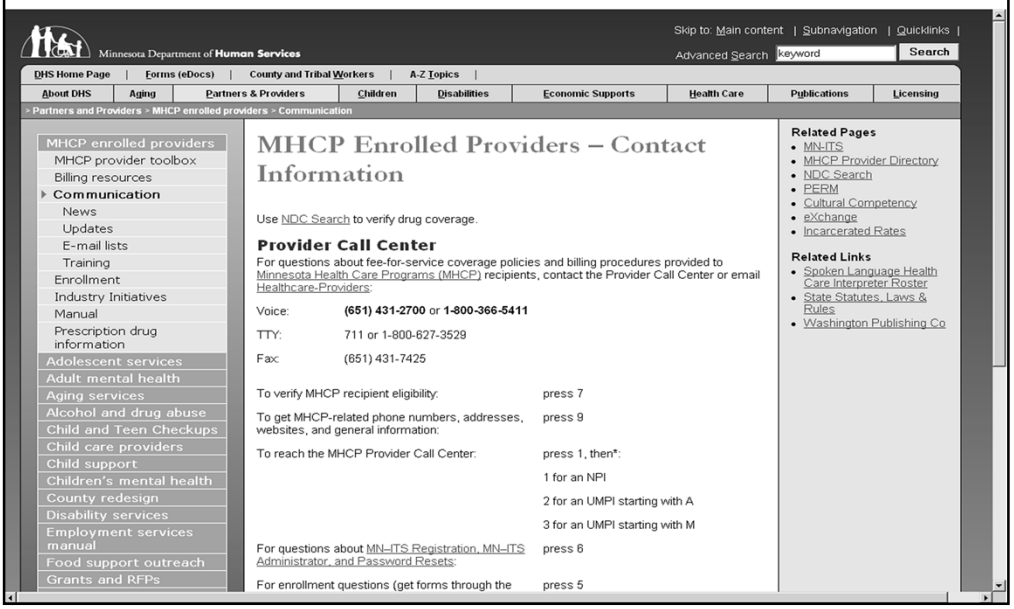
Providers can use the WPC lists to look up HIPAA compliant codes that are displayed on your claim responses and your remittance advices.



Our final link on the right navigation menu can be used to locate information on how to reach MHCP if you have additional Questions or Comments.

Select **Contact Us**.

MHCP Contact Information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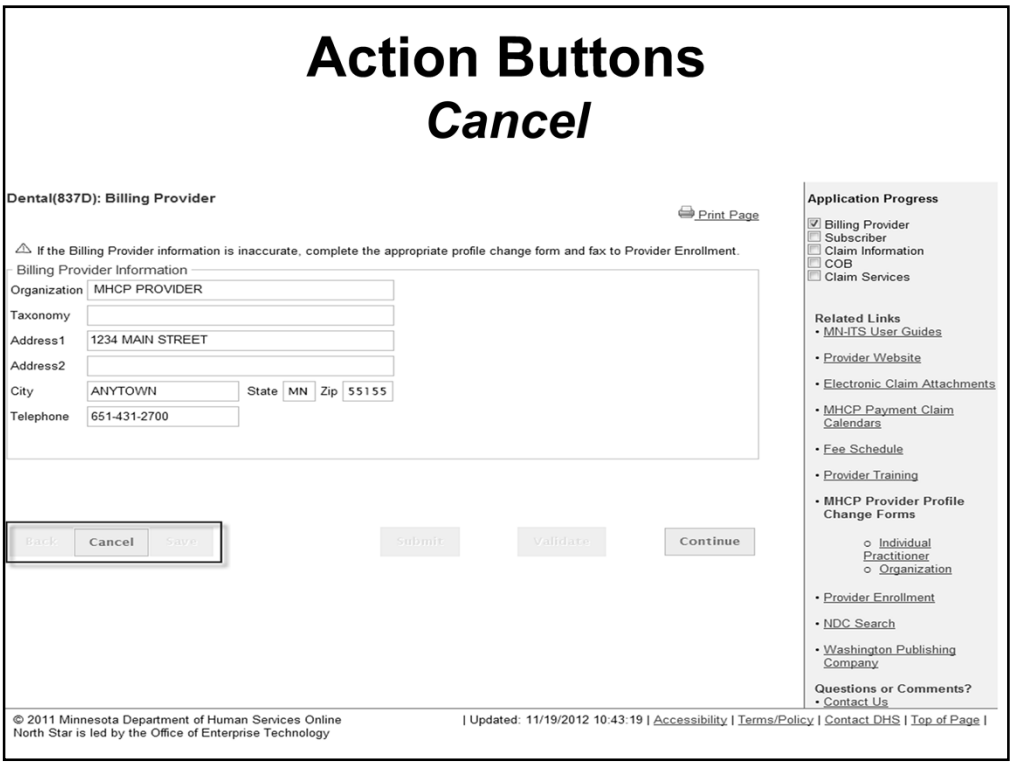
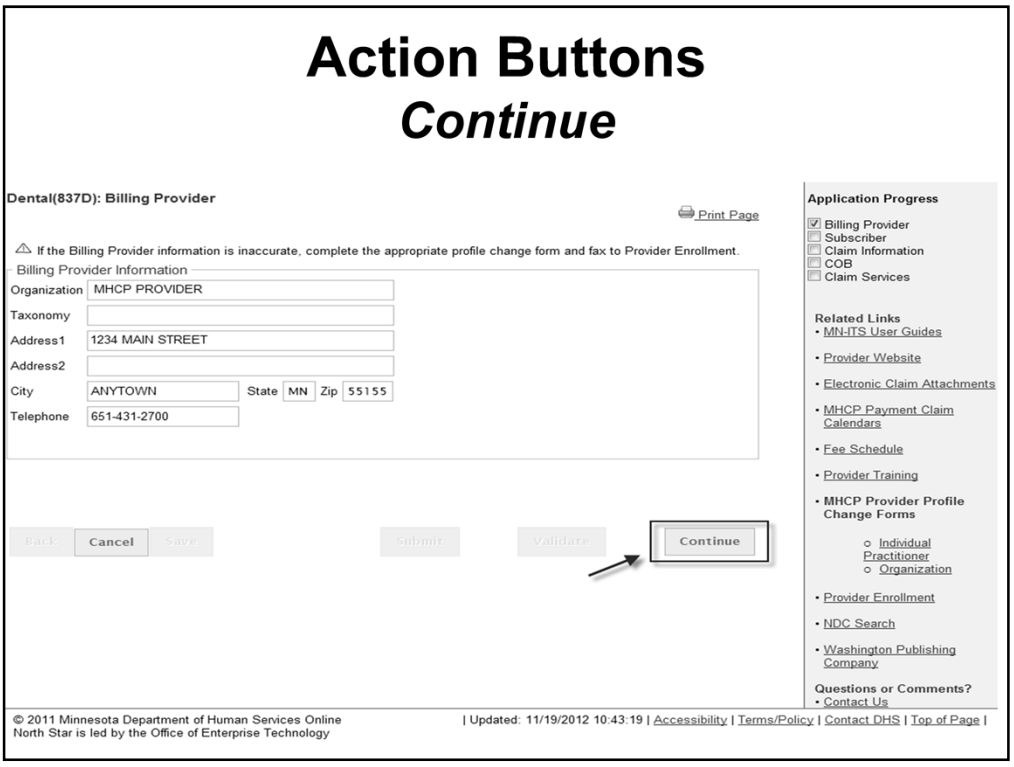
MHCP Enrolled Providers – Contact Information
Use NDC Search to verify drug coverage.
Provider Call Center
For questions about fee-for-service coverage policies and billing procedures provided to Minnesota Health Care Programs (MHCP) recipients, contact the Provider Call Center or email Healthcare-Providers:
Voice: (651) 431-2700 or 1-800-366-5411
TTY: 711 or 1-800-627-3529
Fax: (651) 431-7425
To verify MHCP recipient eligibility: press 7
To get MHCP-related phone numbers, addresses, websites, and general information: press 9
To reach the MHCP Provider Call Center: press 1, then*:
1 for an NPI
2 for an UMPI starting with A
3 for an UMPI starting with M
For questions about MN–ITS Registration, MN–ITS Administrator, and Password Resets: press 6
For enrollment questions (get forms through the press 5
Related Pages
MN-ITS
MHCP Provider Directory
NDC Search
PERM
Cultural Competency
eXchange
Incarcerated Rates
Related Links
Spoken Language Health Care Interpreter Roster
State Statutes, Laws & Rules
Washington Publishing Co

The contact information in the center defines the process for using the Provider Call Center and the options available.

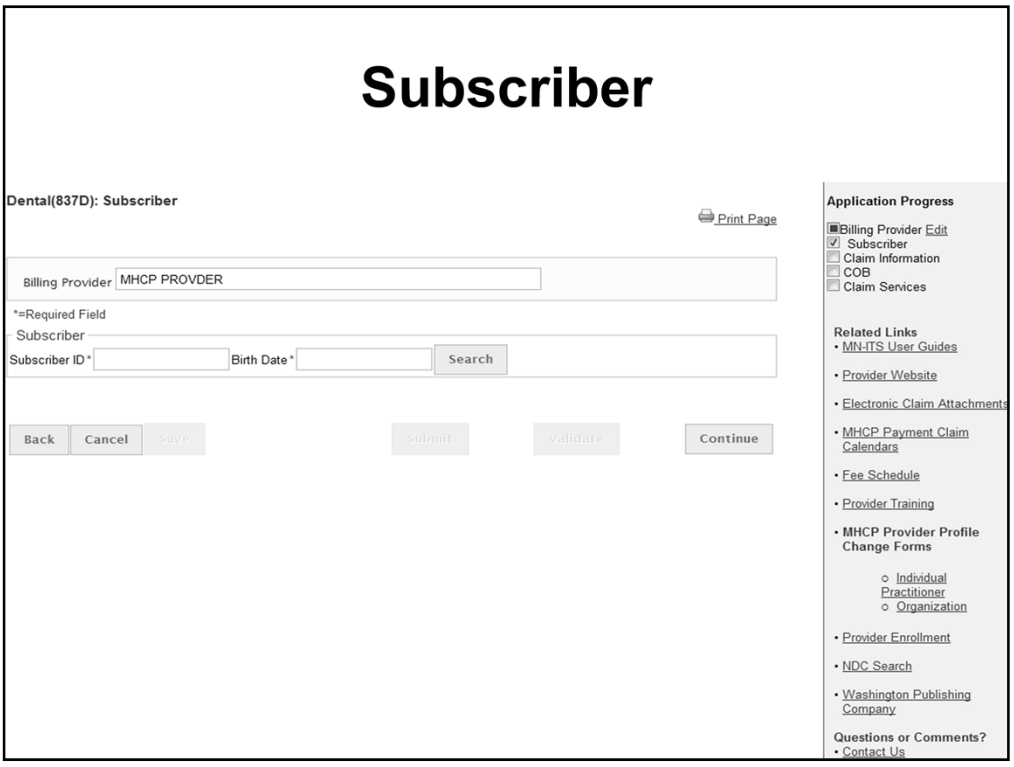


On the Billing Provider screen there are several action buttons below the billing provider fields. Some may be protected or hidden as this is the first screen; and the claim is not complete.

On this screen the options are to cancel the claim or continue.

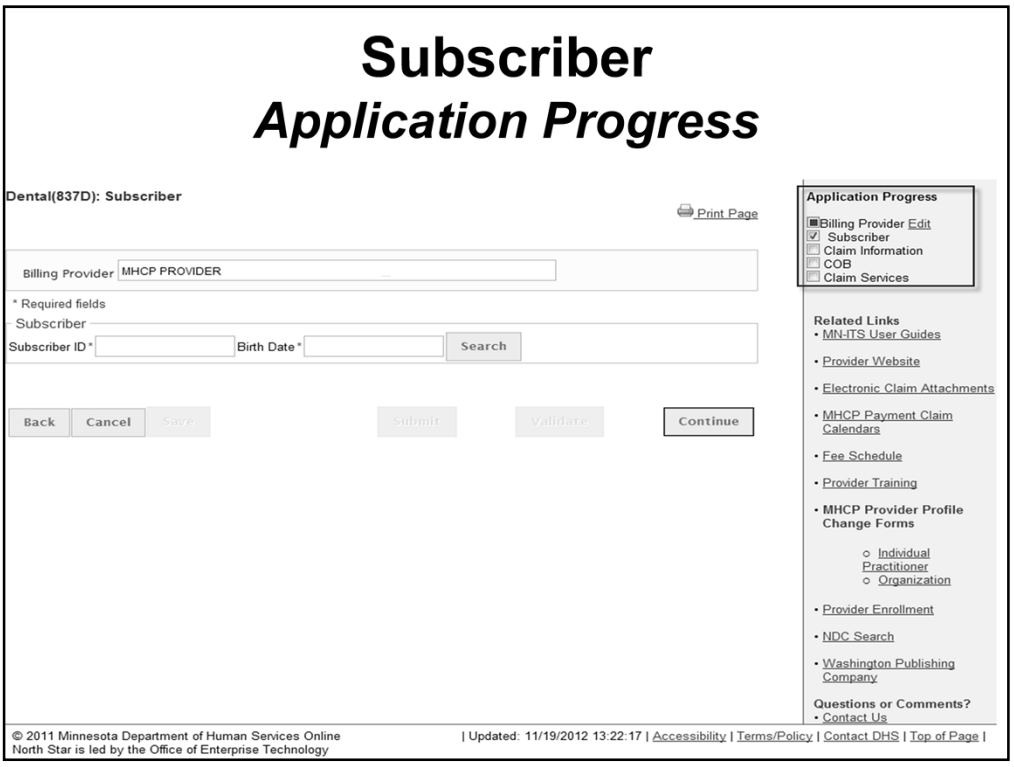


Select **Continue**, to move to the Subscriber screen.



The Subscriber screen is the second screen in the claim process. As we continue to move through the screens the Billing Provider name continues to display.

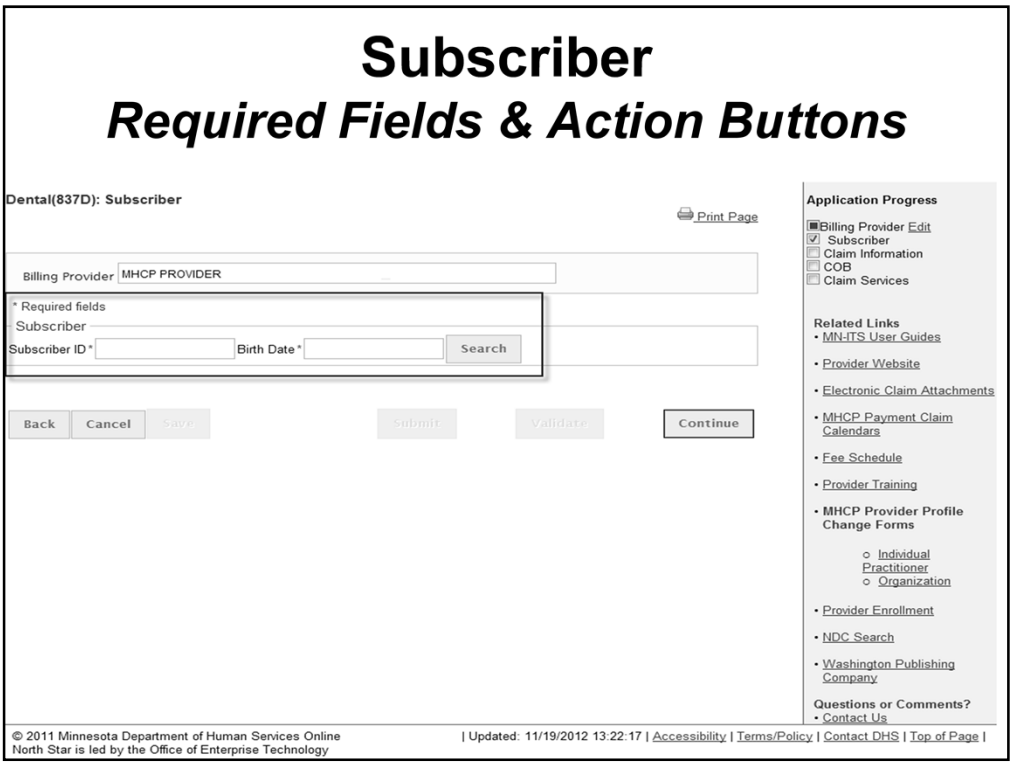
On the subscriber screen you will enter the FFS MHCP recipient's member ID and their birthdate.



The Application Progress feature in the upper right navigation is now updating our progress through the screens. A **checkmark** in the box next to the **screen name** indicates we are on the Subscriber screen.

The box next to the **Billing Provider screen name** is now **filled in**, indicating it has been completed. Once completed an **Edit** link will display after the **screen name**: such as seen next to Billing Provider.

By selecting a **edit** link you can return to a completed screen to review or make any necessary corrections.



Required fields on the New MN–ITS Screens are now indicated with single red asterisks in the Subscriber section.

Throughout the new MN-ITS screens, single red asterisks indicate fields that must be completed before continuing to the next screen.

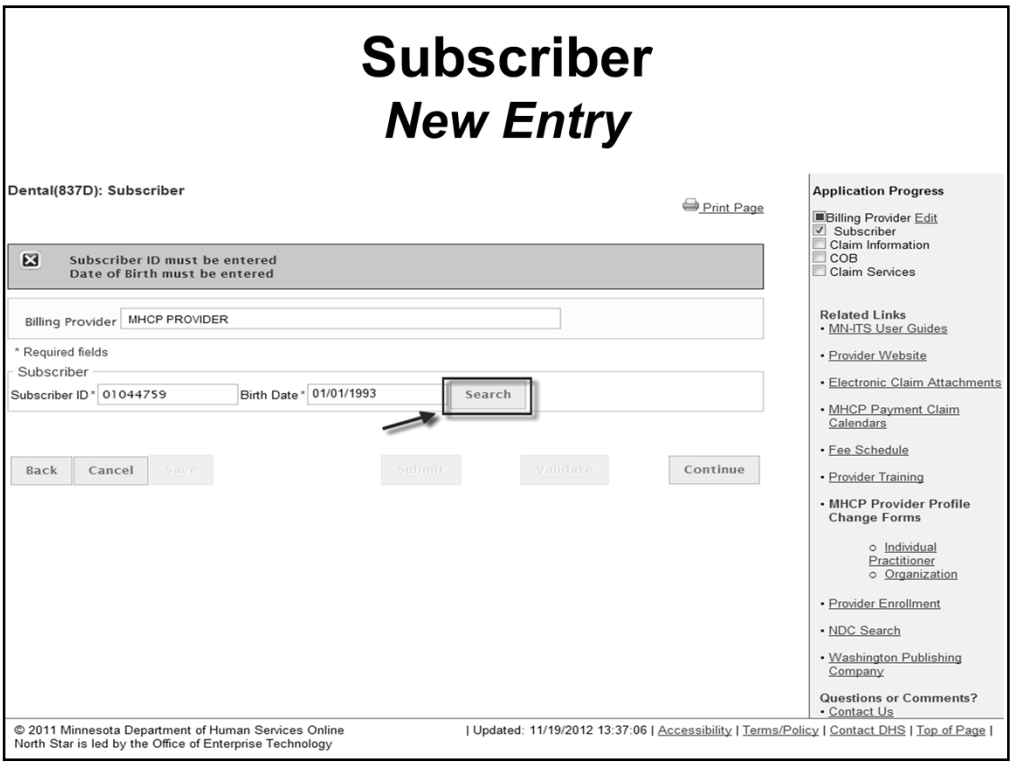
Once past the Provider Screen the **Back** action button displays, and when selected will return you to the provider screen.

Subscriber
Error Message

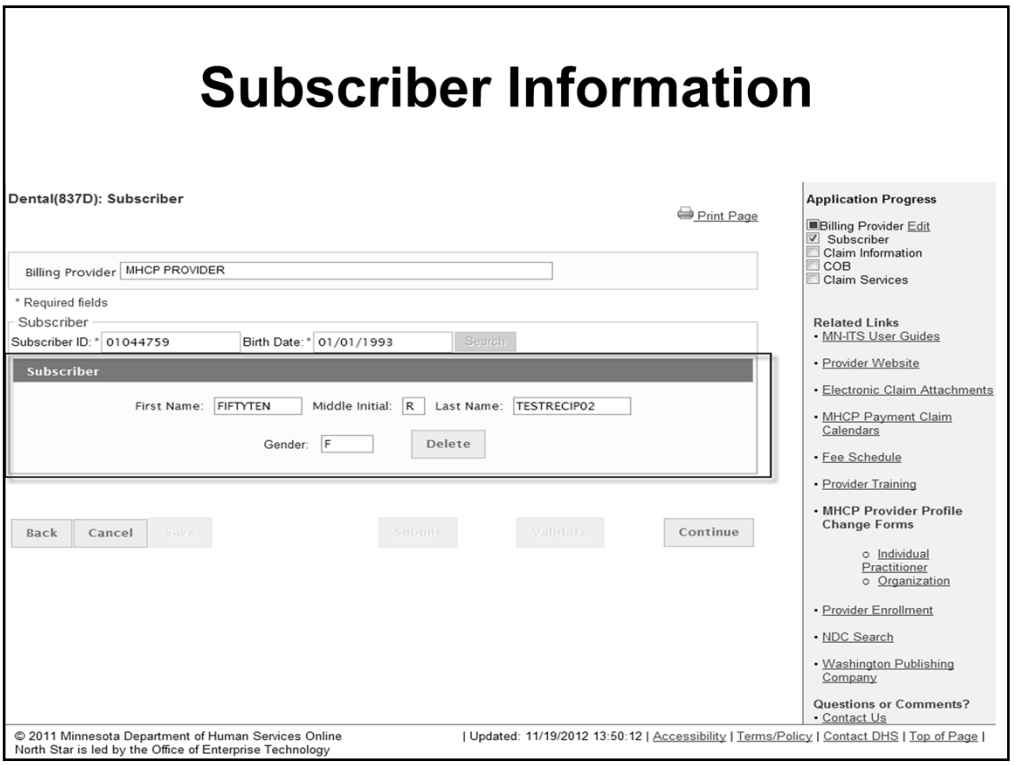
If you select either the **search** or **continue** action buttons without completing the required fields you will receive a message stating; “Subscriber ID must be entered, Date of Birth must be entered.”

Subscriber
Invalid Search Response

If the subscriber ID and birthdate you enter does not match information on file for a MHCP recipient, you will receive a message stating, “Subscriber not found.”



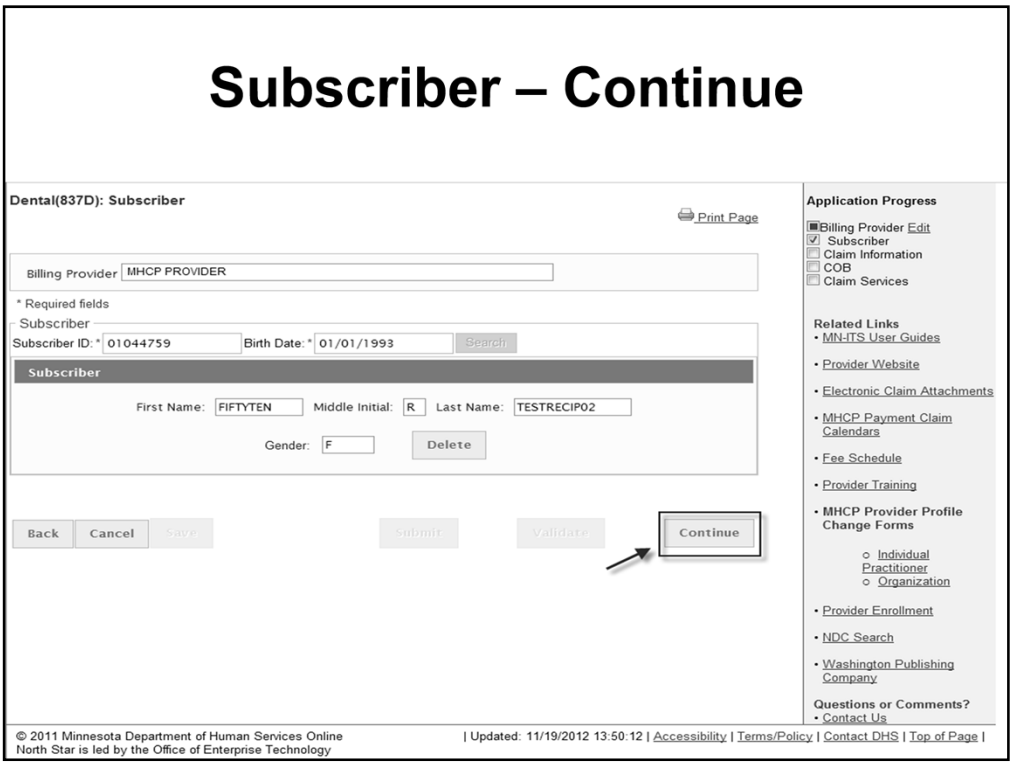
Once you have correctly completed the subscriber ID and their birthdate, select the **Search** action button.



When a match is found, additional subscriber information is displayed in a table that has protected fields that cannot be modified.

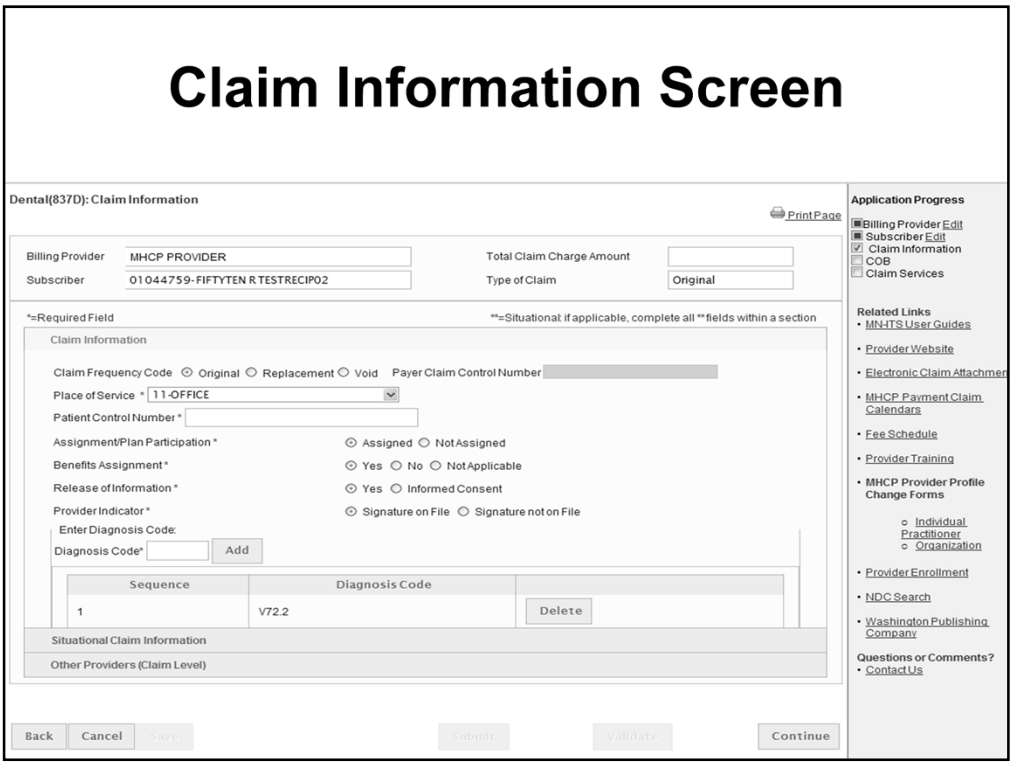
Finding a match does not guarantee the recipient is eligible for the service your are providing. Providers are required to verify eligibility prior to preforming the service. Using the MN–ITS Eligibility Request is the best way for you to make sure they are currently eligible on a fee-for-service major program that covers the dental service you are providing.

Subscriber – Continue



If the subscriber displayed is correct for your claim, select the **continue** action button to move on to the next screen Claim Information.

Claim Information Screen

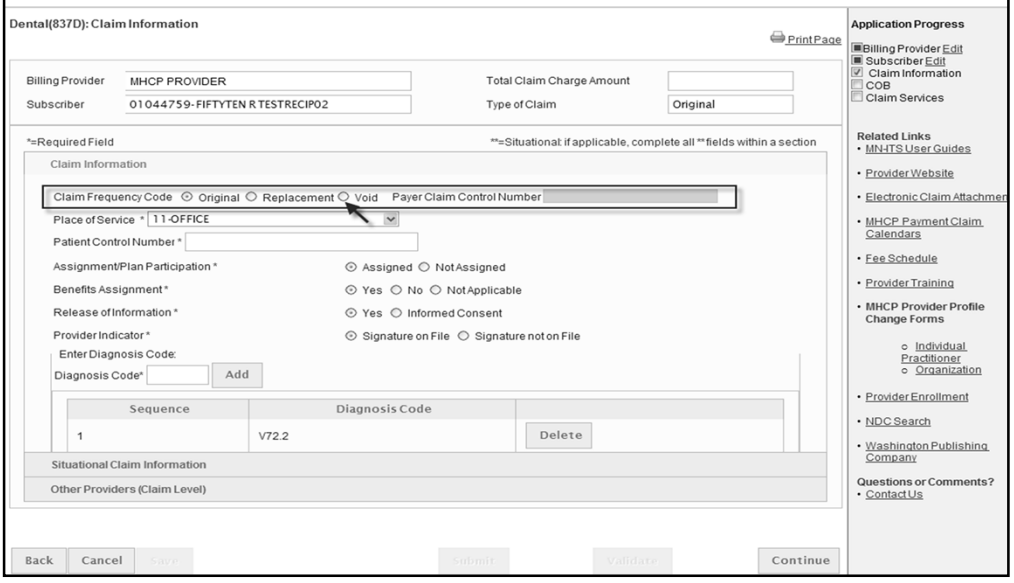


The Claim Information screen contains three sections that open and close as you select them. The screen opens displaying the Claim Information section, with an orange title.

The other two sections below: Situational Claim Information and Other Providers (Claim Level) are display in a blue panel across the screen, indicating they are closed. These sections are called accordion panels.

First, let's discuss the Claim Information section.

Replacement/Void
Radio Buttons/Protected Fields

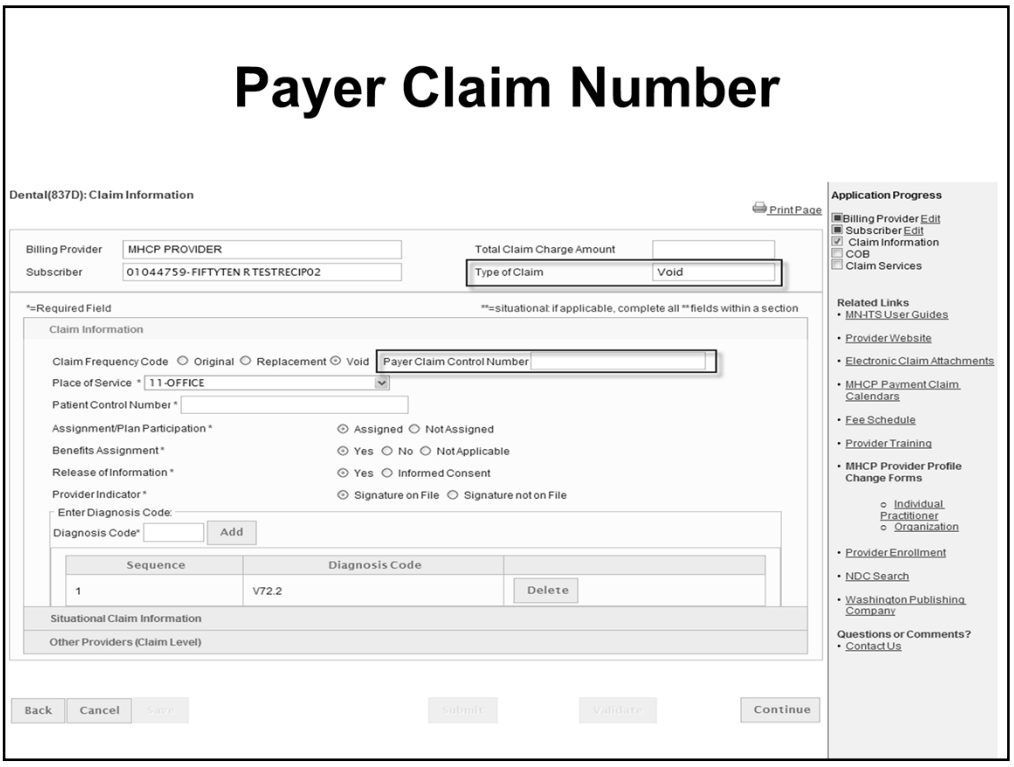


Providers use radio buttons to select options for specific fields such as the Claim Frequency Code field.

Providers may choose to select Original, Replacement or Void a claim.

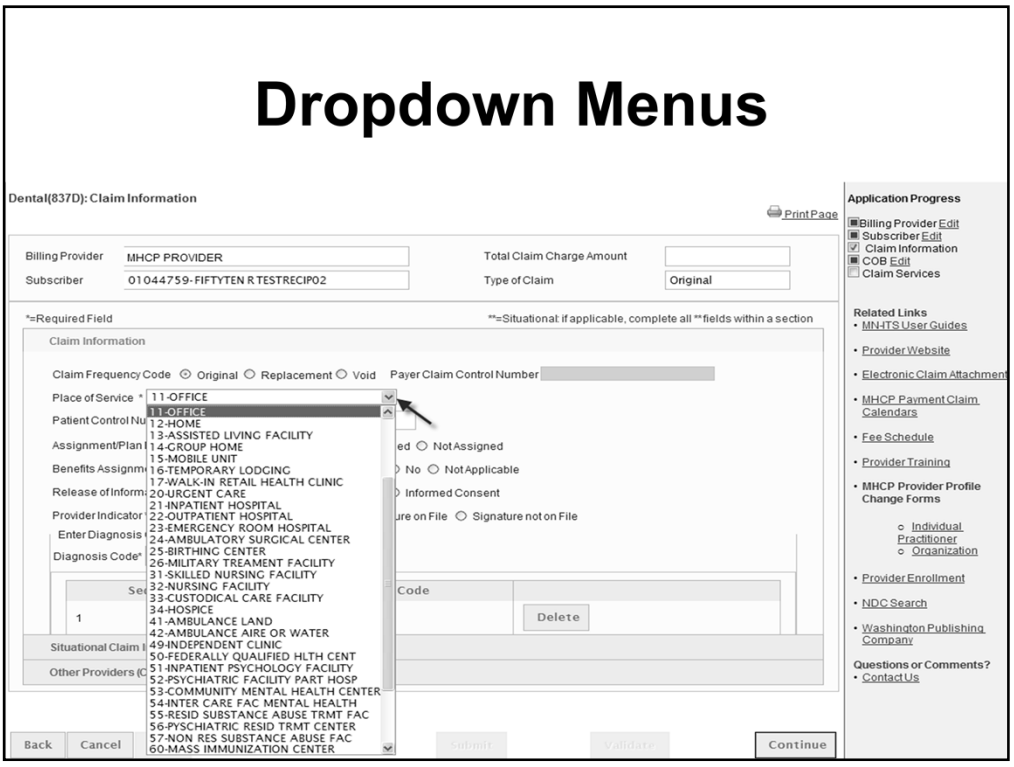
The Payer Claim Control number field cannot be modified when the radio button selected is for an original Claim.

Payer Claim Number

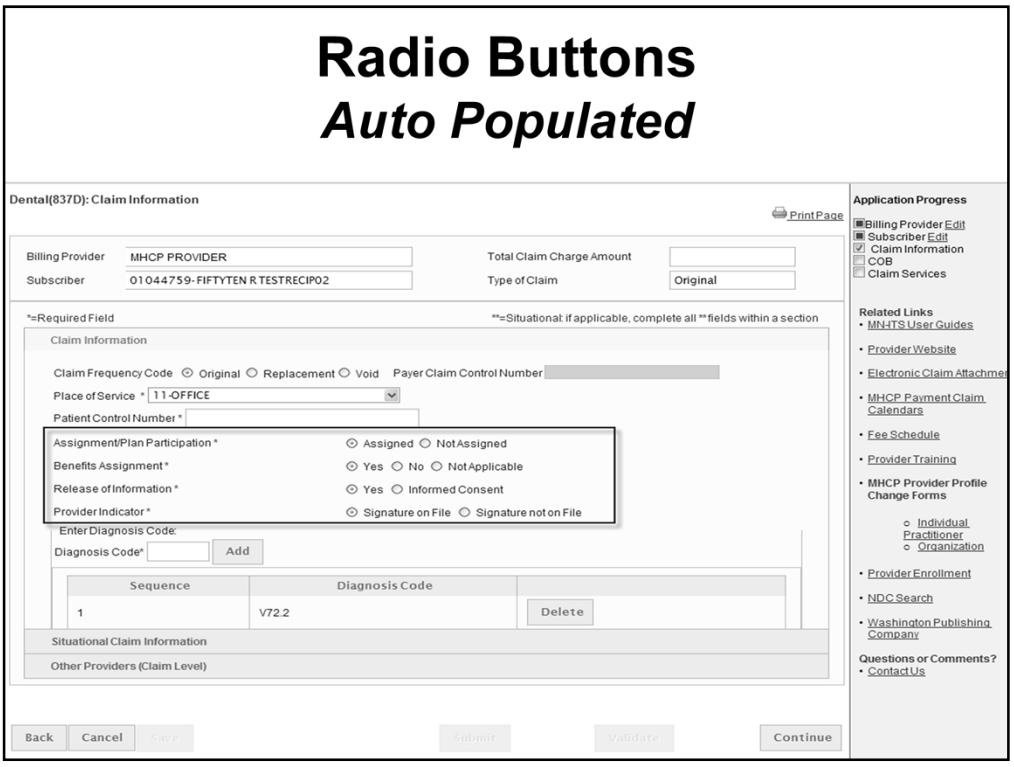


When Replacement or Void is selected, the type of claim will change, and the Payer Claim Control Number field turns white to allow provider to enter the payer claim number of the claim they are trying to replace or void.

Dropdown Menus



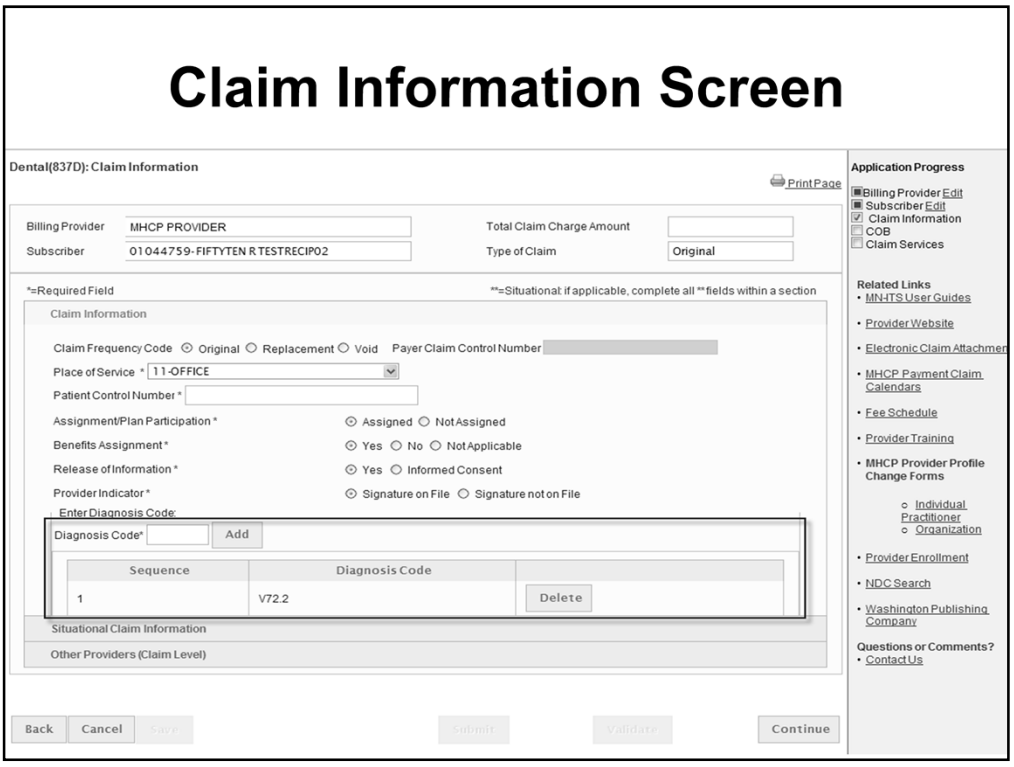
Some features remain the same, such as the place of service field drop down menus that allow you to select from a list of valid values.



The assignment/plan participation, benefits assignment, release of information and provider indicator fields are automatically default with the standard responses assigned, yes and signature on file.

If the default response is incorrect, select the radio button for the response that best describes the actual documentation the provider has on file.

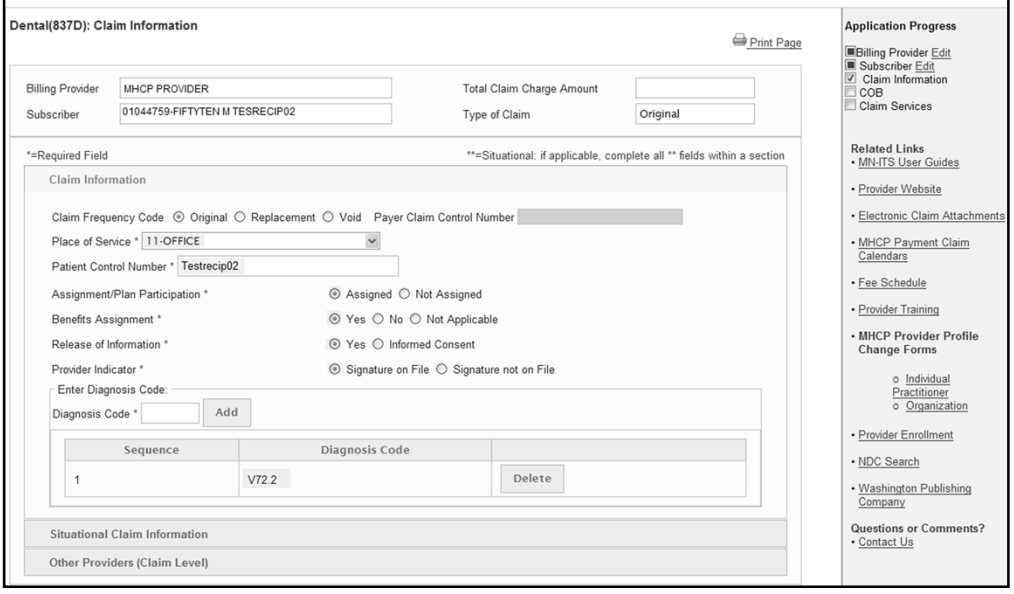
Claim Information Screen



A diagnosis code is now required on all claim types. The new MN–ITS screens diagnosis field will be defaulted on the Dental Claim with V72.2 for General Dental Examination.

Providers can also add additional diagnosis codes for the claim by entering the appropriate ICD9 code and selecting the **Add** action button to save the entry.

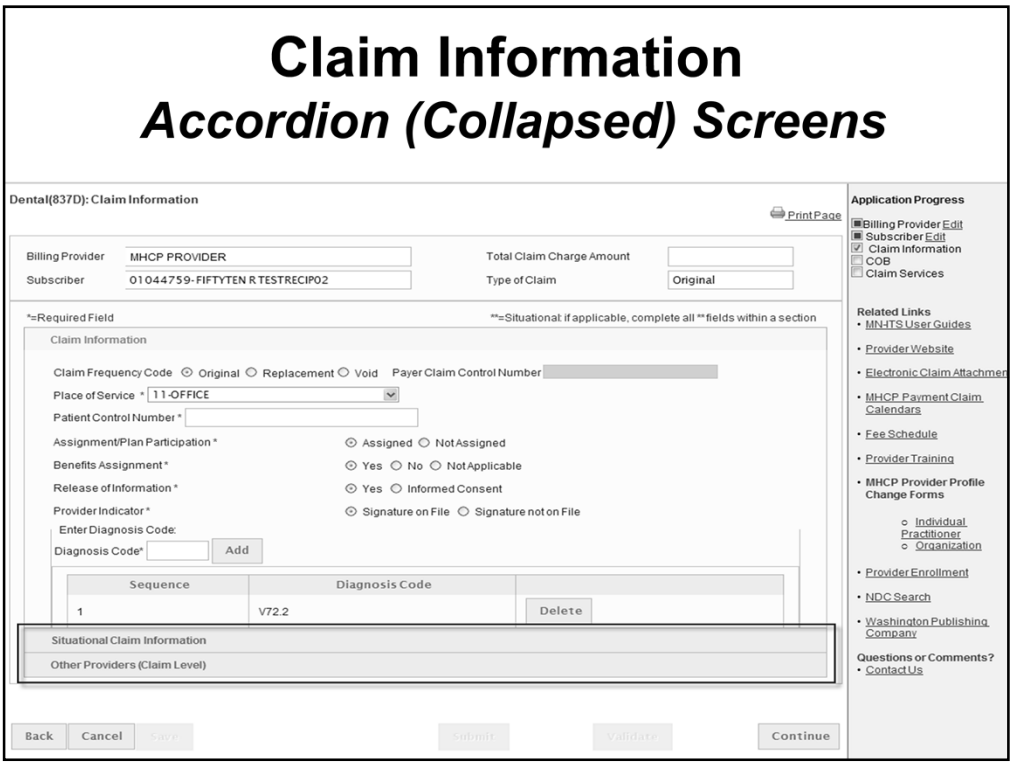
Claim Information
All Required Fields Completed



Make sure all of the required fields have been completed before moving to the next accordion panel or screen. They are:

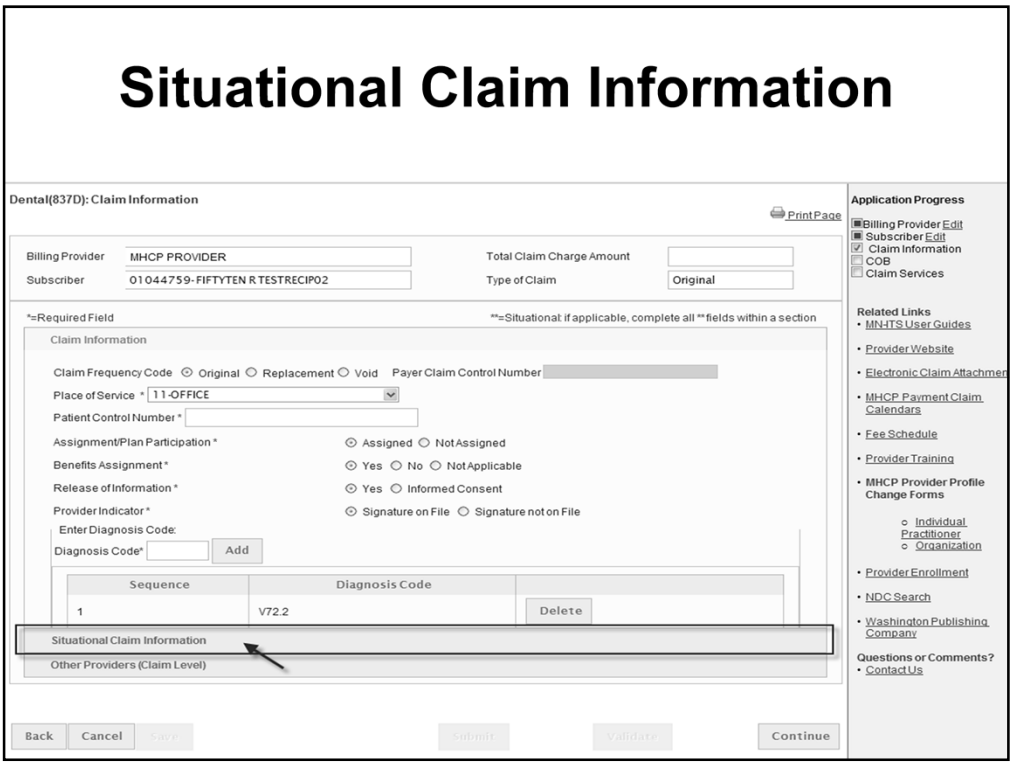
- Place of service
- Patient control number
- Assignments
    - Plan participation
    - Benefits assignment
    - Release of information
    - Provider indicator and the
    - Diagnosis code

Claim Information
Accordion (Collapsed) Screens



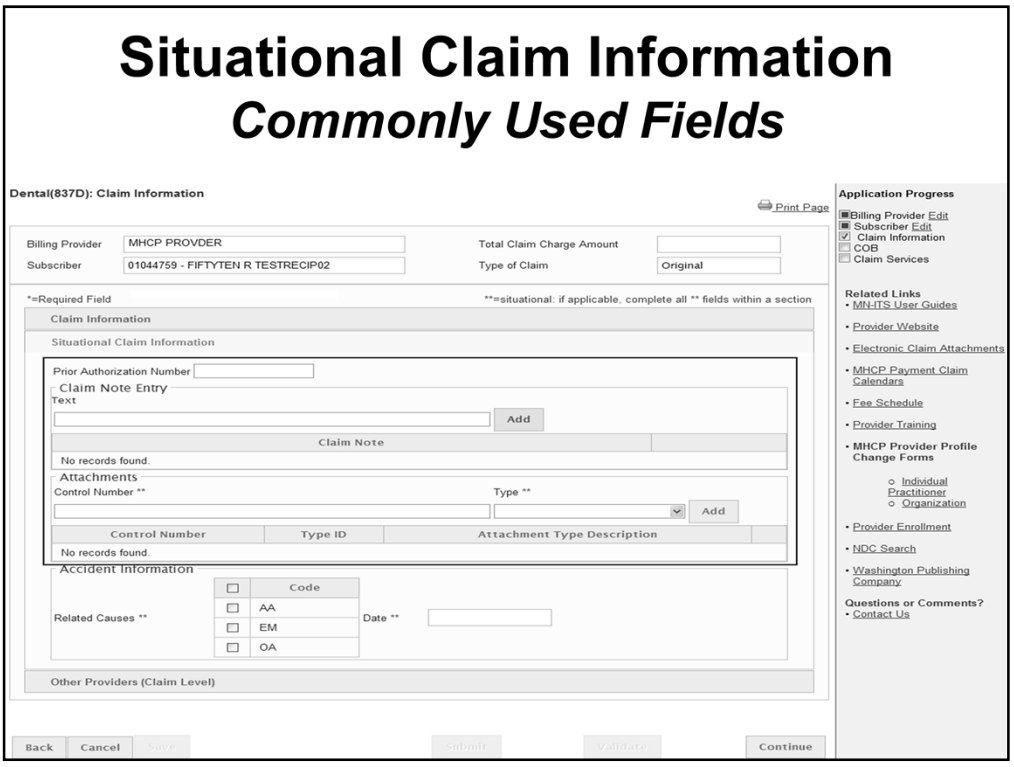
The Situational Claim Information and Other Providers (Claim Level) sections are currently collapsed (or closed).

Situational Claim Information



Next we will select the accordion panel for **Situational Claim Information**.

Situational Claim Information
Commonly Used Fields



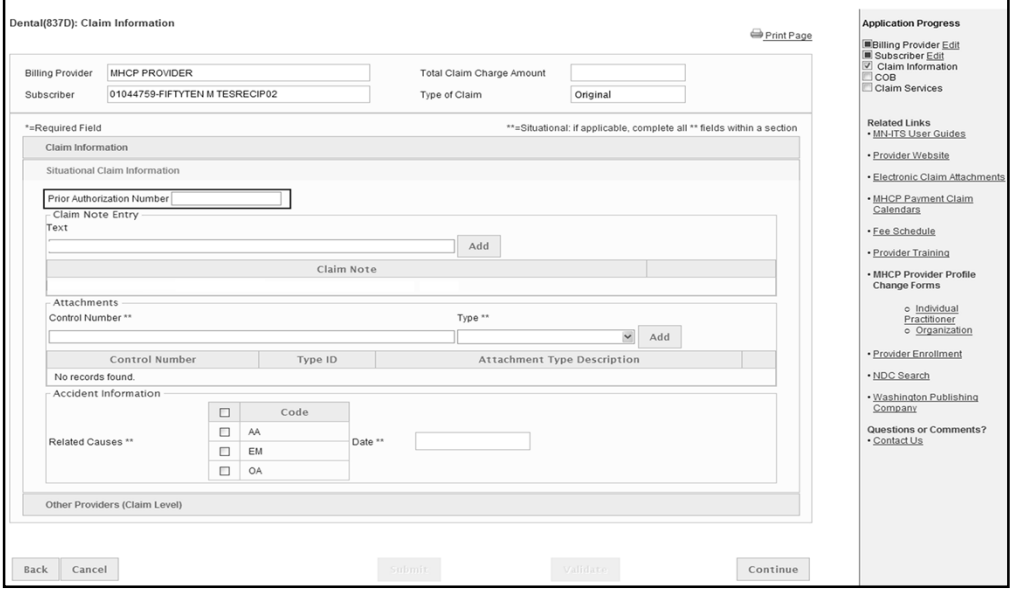
We are now in the Situational Claim Information section, indicated with an orange title. The Claim Information section has collapsed and is displayed with a blue accordion panel above the opened situational claims information section.

The Situational Claim Information section contains information that may be required depending on the services performed.

There are double red asterisks next to several fields.

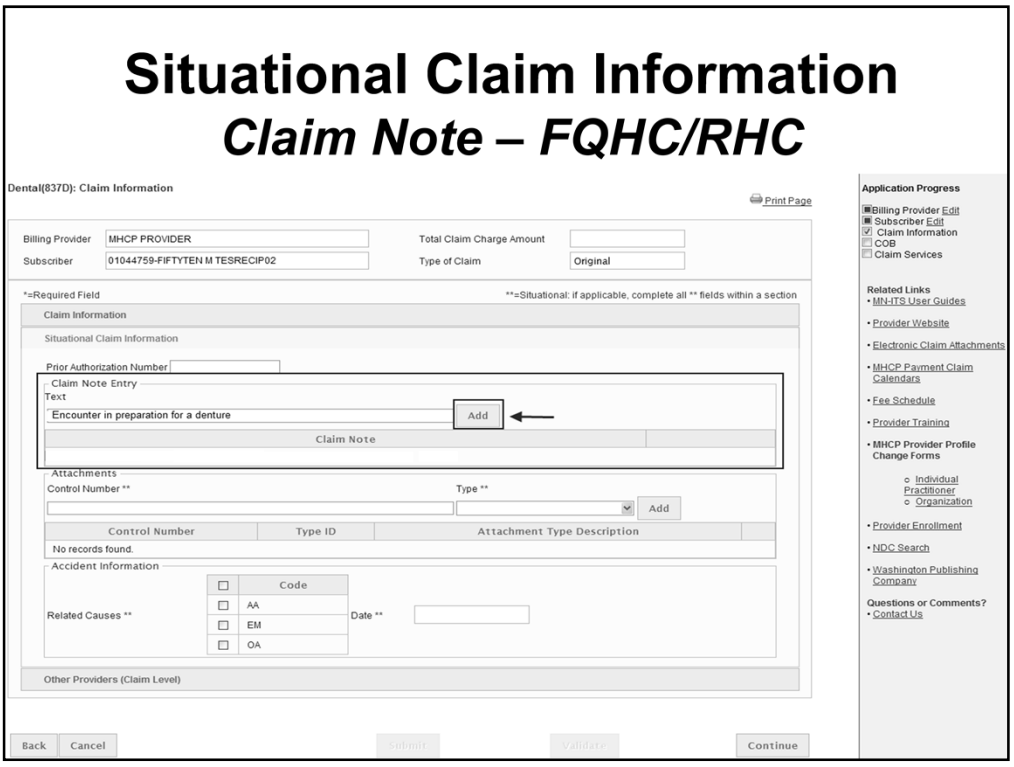
Throughout the new MN-ITS screens Double red asterisks indicate fields that are situational. If applicable, complete all situational fields within the same subsection. Subsections are grouped in blue outlined boxes, such as seen Attachments or Accident Information. Refer to the MN-ITS user manual user guides for instructions regarding specific services.

Situational Claim Information
MHCP Authorization Number



If the service you are billing requires an authorization, use the prior authorization number field to enter the assigned 11- digit MHCP authorization number.

Situational Claim Information
Claim Note – FQHC/RHC



For most providers a claim note is not needed. However, if you are a FQHC, RHC or IHS Provider that is billing a non-specified dental code for a:

- Fee-for service recipient who is enrolled in MinnesotaCare major program BB, and
- Is receiving services for a partial denture or full denture

You must enter the specific description that is listed in our MHCP Provider Manual Clinics sections into the Claim Note Entry Field, or your claim will deny.

For services prior to the delivery of the prosthesis enter the claim note as follows:

- “Encounter in preparation of a denture” or
- “Encounter in preparation of a partial”

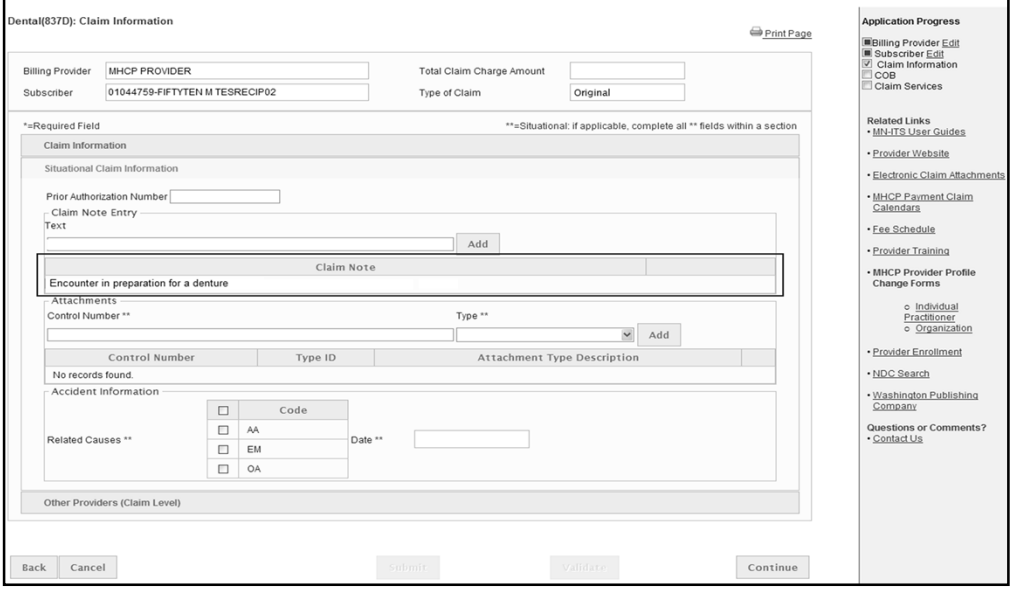
For service after the delivery of the prosthesis enter the claim note as follows:

- “Encounter for denture adjustment” or
- “Encounter for partial denture adjustment”

After you have entered your claim note, select the **Add** action button to save

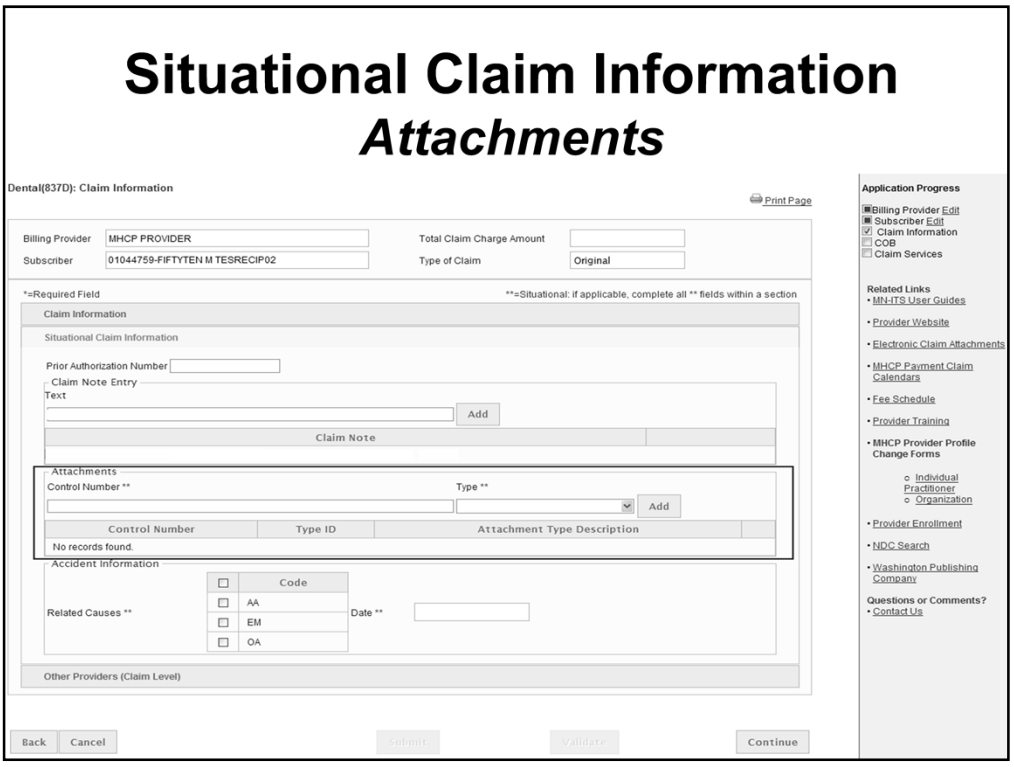
the entry.

Situational Claim Information
Claim Note – Added



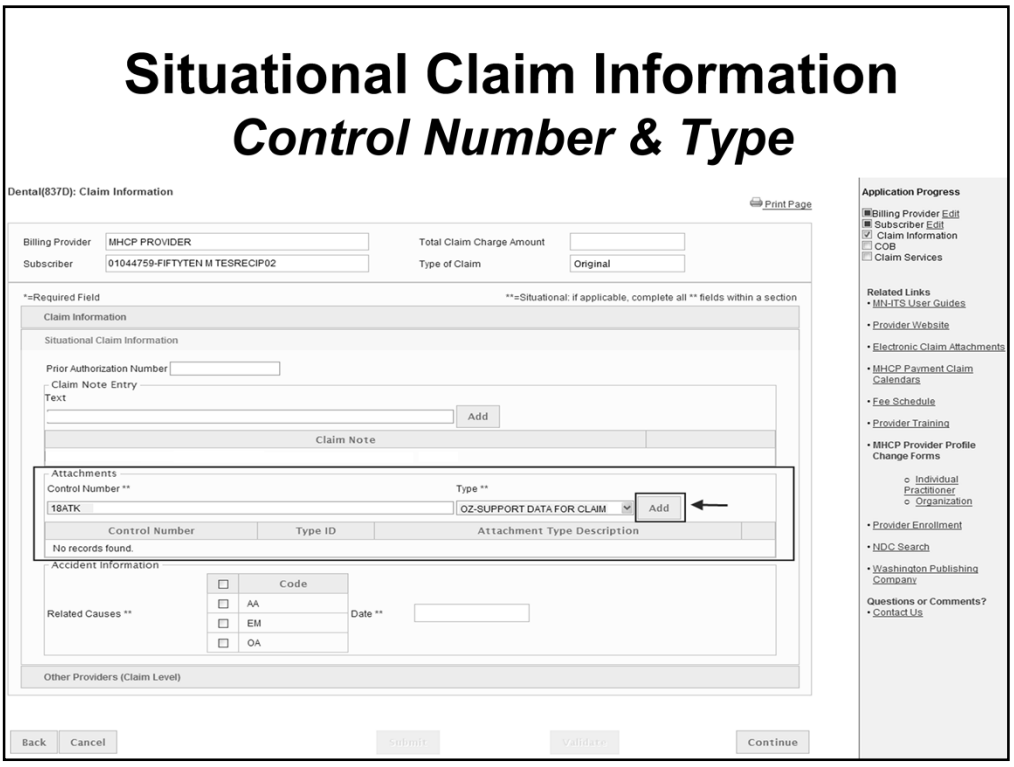
The saved claim note will display in the claim note table.

Situational Claim Information
Attachments

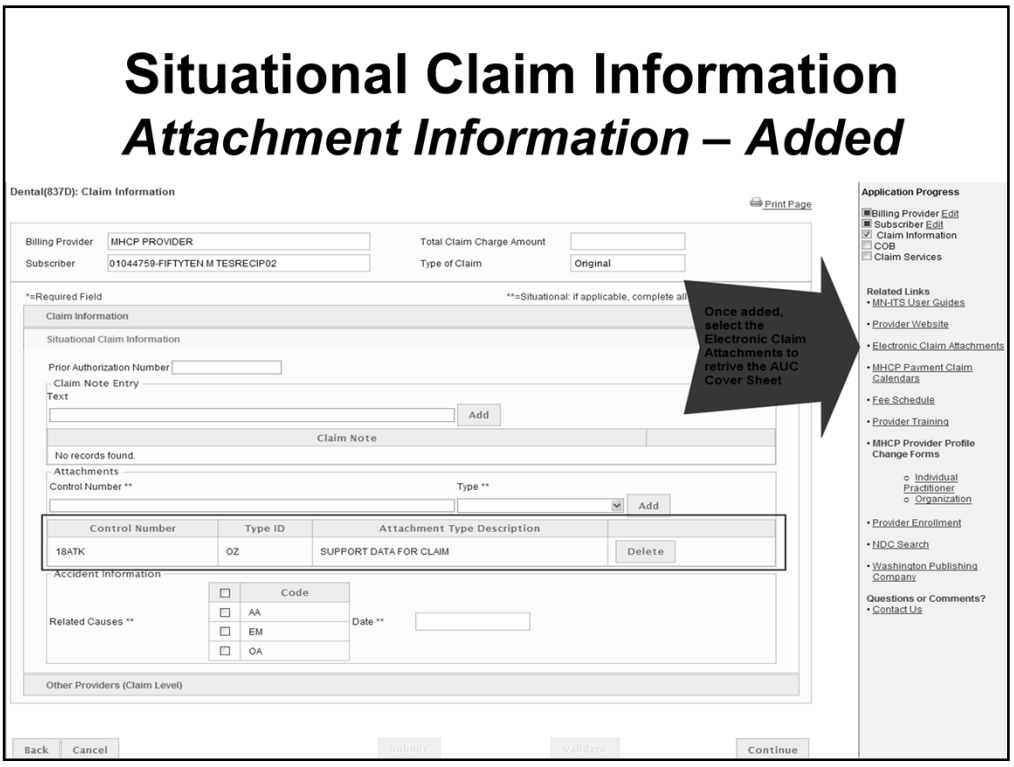


The attachments subsection is used to enter your claims attachment control number and the claims attachment type when supporting documentation must be provided for MHCP to process the claim.

Situational Claim Information
Control Number & Type

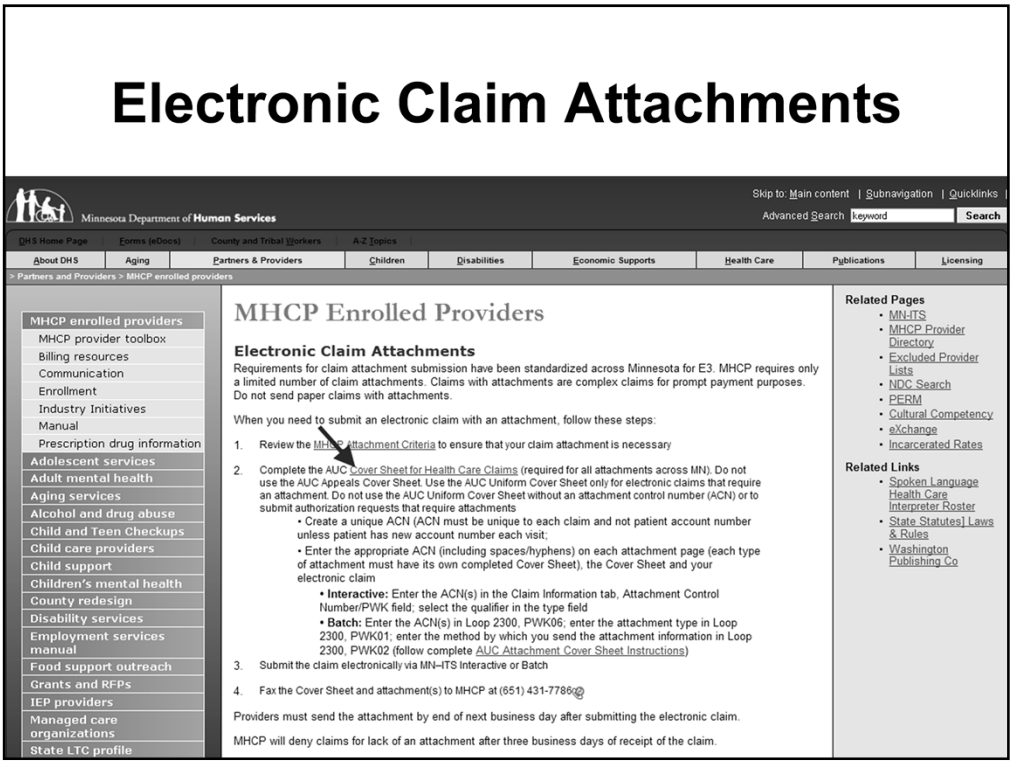


The attachment control number must be unique to this individual claim and is created by the Provider. For dental claims use Type OZ which equals Support data for claim. Then select the Add action button to save the entry.

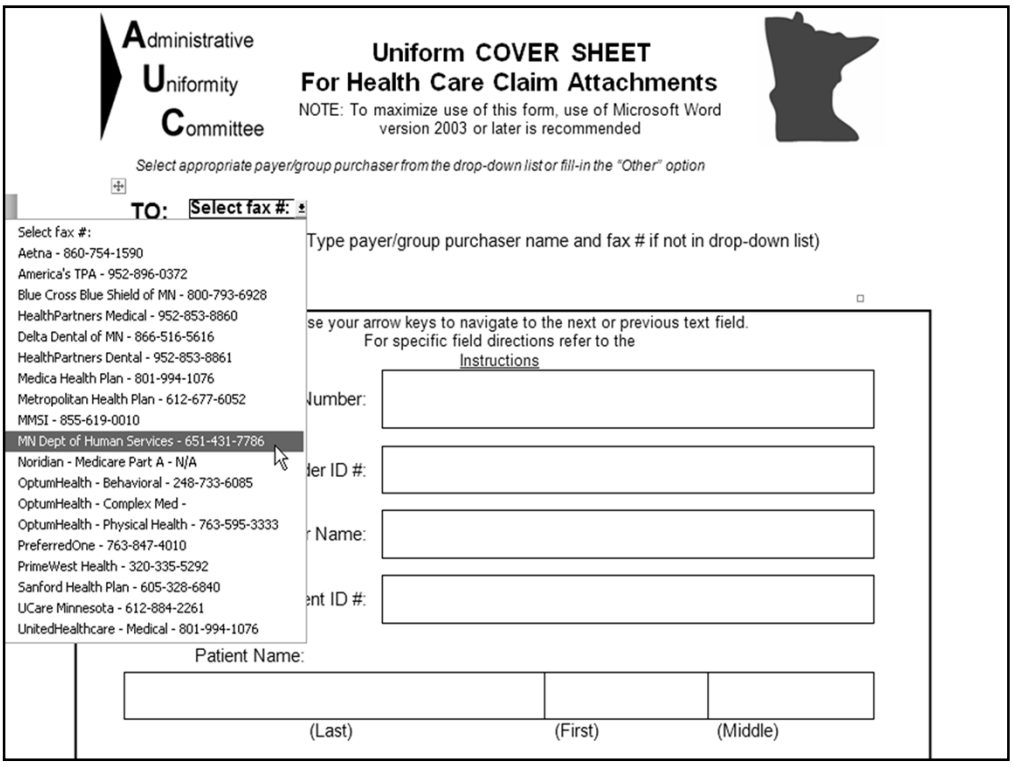


Once the claims attachment information is saved, providers can go the right navigation menu and select **Electronic Claims Attachment** to retrieve the AUC cover sheet.

Electronic Claim Attachments


Skip to: Main content | Subnavigation | Quicklinks |
Minnesota Department of Human Services
Advanced Search keyword Search
DHS Home Page | Forms (eDocs) | County and Tribal Workers | A-Z Topics
About DHS | Aging | Partners & Providers | Children | Disabilities | Economic Supports | Health Care | Publications | Licensing
> Partners and Providers > MHCP enrolled providers
MHCP enrolled providers
MHCP provider toolbox
Billing resources
Communication
Enrollment
Industry Initiatives
Manual
Prescription drug information
Adolescent services
Adult mental health
Aging services
Alcohol and drug abuse
Child and Teen Checkups
Child care providers
Child support
Children's mental health
County redesign
Disability services
Employment services manual
Food support outreach
Grants and RFPs
IEP providers
Managed care organizations
State LTC profile
MHCP Enrolled Providers
Electronic Claim Attachments
Requirements for claim attachment submission have been standardized across Minnesota for E3. MHCP requires only a limited number of claim attachments. Claims with attachments are complex claims for prompt payment purposes. Do not send paper claims with attachments.
When you need to submit an electronic claim with an attachment, follow these steps:
1. Review the MHCP Attachment Criteria to ensure that your claim attachment is necessary
2. Complete the AUC Cover Sheet for Health Care Claims (required for all attachments across MN). Do not use the AUC Appeals Cover Sheet. Use the AUC Uniform Cover Sheet only for electronic claims that require an attachment. Do not use the AUC Uniform Cover Sheet without an attachment control number (ACN) or to submit authorization requests that require attachments
• Create a unique ACN (ACN must be unique to each claim and not patient account number unless patient has new account number each visit;
• Enter the appropriate ACN (including spaces/hyphens) on each attachment page (each type of attachment must have its own completed Cover Sheet), the Cover Sheet and your electronic claim
• Interactive: Enter the ACN(s) in the Claim Information tab, Attachment Control Number/PWK field; select the qualifier in the type field
• Batch: Enter the ACN(s) in Loop 2300, PWK06; enter the attachment type in Loop 2300, PWK01; enter the method by which you send the attachment information in Loop 2300, PWK02 (follow complete AUC Attachment Cover Sheet Instructions)
3. Submit the claim electronically via MN–ITS Interactive or Batch
4. Fax the Cover Sheet and attachment(s) to MHCP at (651) 431-7786
Providers must send the attachment by end of next business day after submitting the electronic claim.
MHCP will deny claims for lack of an attachment after three business days of receipt of the claim.
Related Pages
• MN-ITS
• MHCP Provider Directory
• Excluded Provider Lists
• NDC Search
• PERM
• Cultural Competency
• eXchange
• Incarcerated Rates
Related Links
• Spoken Language Health Care Interpreter Roster
• State Statutes] Laws & Rules
• Washington Publishing Co

The Electronic Claim Attachments Webpage will display. In the center section is a link to the AUC Cover Sheet for Health Care Claims. Select the link to retrieve the document


Administrative
Uniformity
Committee
Uniform COVER SHEET
For Health Care Claim Attachments
NOTE: To maximize use of this form, use of Microsoft Word version 2003 or later is recommended
Select appropriate payer/group purchaser from the drop-down list or fill-in the "Other" option
TO:
Select fax #:
Select fax #:
Aetna - 860-754-1590
America's TPA - 952-896-0372
Blue Cross Blue Shield of MN - 800-793-6928
HealthPartners Medical - 952-853-8860
Delta Dental of MN - 866-516-5616
HealthPartners Dental - 952-853-8861
Medica Health Plan - 801-994-1076
Metropolitan Health Plan - 612-677-6052
MMSI - 855-619-0010
MN Dept of Human Services - 651-431-7786
Noridian - Medicare Part A - N/A
OptumHealth - Behavioral - 248-733-6085
OptumHealth - Complex Med -
OptumHealth - Physical Health - 763-595-3333
PreferredOne - 763-847-4010
PrimeWest Health - 320-335-5292
Sanford Health Plan - 605-328-6840
UCare Minnesota - 612-884-2261
UnitedHealthcare - Medical - 801-994-1076
Type payer/group purchaser name and fax # if not in drop-down list)
se your arrow keys to navigate to the next or previous text field.
For specific field directions refer to the
Instructions
Number:
der ID #:
r Name:
ent ID #:
Patient Name:
(Last)
(First)
(Middle)

Select fax # to display a drop-down list of fax numbers for the payers, and select MN Dept of Human Services – 651-431-7786.

MHCP only accepts claims attachments at this fax number.

Administrative Uniformity Committee

Uniform COVER SHEET
For Health Care Claim Attachments
NOTE: To maximize use of this form, use of Microsoft Word version 2003 or later is recommended

Select appropriate payer/group purchaser from the drop-down list or fill-in the "Other" option

TO: **Select fax #:** MN Dept of Human Services - 651-431-7786

Other fax #: (Type payer/group purchaser name and fax # if not in drop-down list)
Name: MHCP
Fax #: 651-431-7786

Tab or use your arrow keys to navigate to the next or previous text field.
For specific field directions refer to the Instructions

Attachment Control Number:	18ATK
Billing Provider ID #:	1234567890
Billing Provider Name:	MHCP PROVIDER
Patient ID #:	03906179

Patient Name:

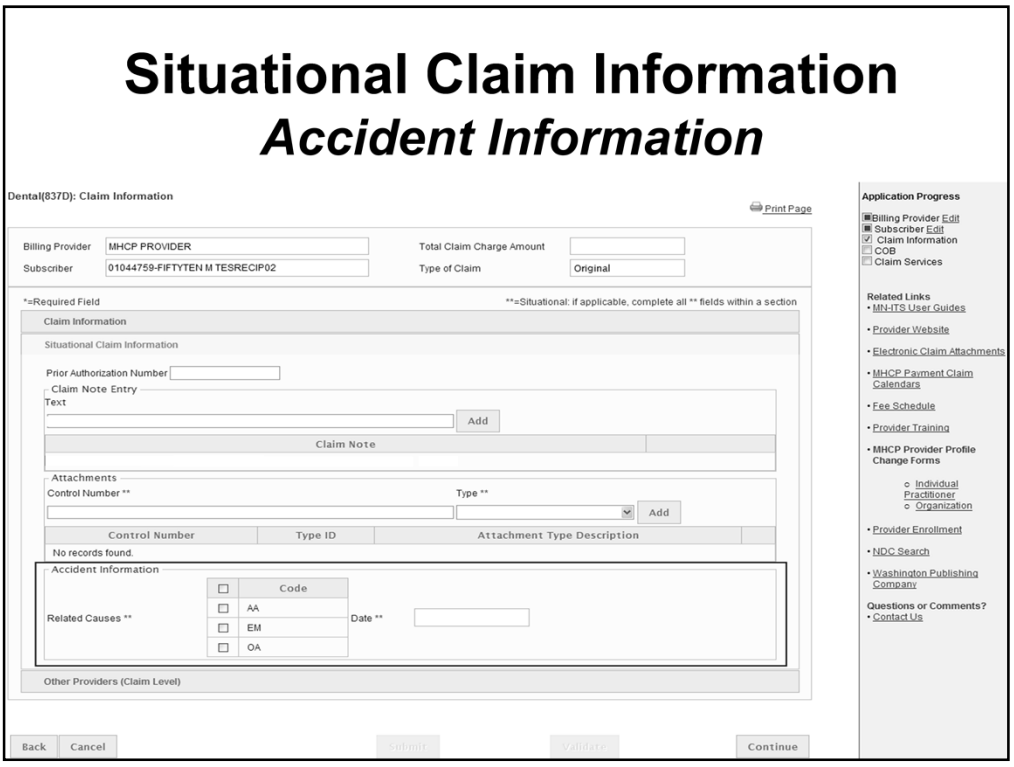
TESTRECIP02 (Last)	FIFTYTEN (First)	M (Middle)

Property and Casualty Claim #:	
Attachment Send Date:	
Total Number of Pages:	2
Contact Name/Phone #:	A. Biller 651-123-4567

Complete the document matching the attachment control number, billing provider ID number and name, as well as the recipients name that matches your claim. Indicate the total number of pages and a contact name and phone number.

Fax the AUC cover sheet along with all supporting documentation to the fax number selected for MHCP.

Situational Claim Information
Accident Information



The next subsection is Accident Information. If the service is related to an accident, use the appropriate related causes indicator :

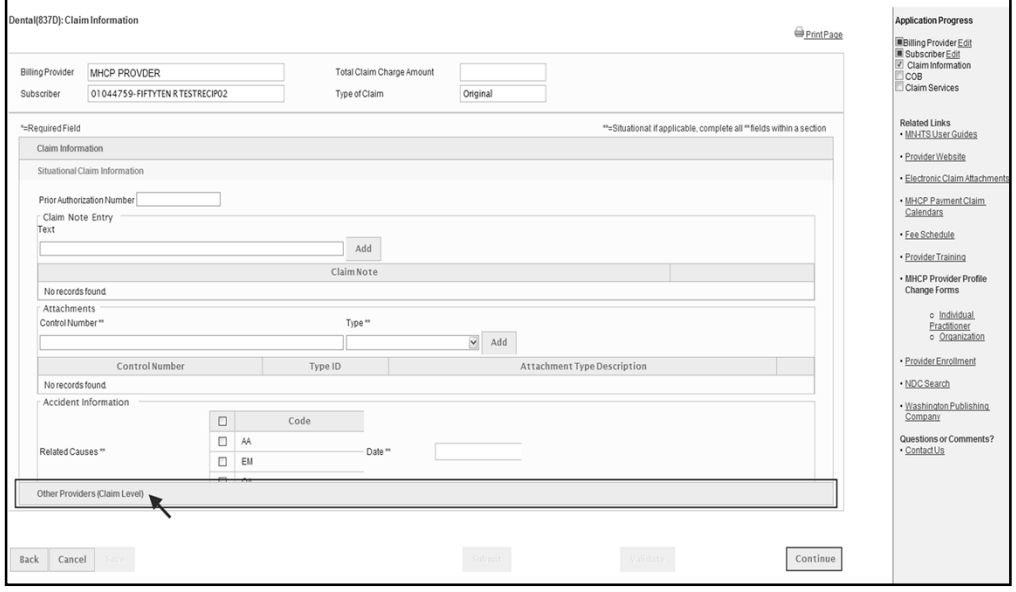
AA = Auto accident

EM = Employment related accident

OA = Other Accident

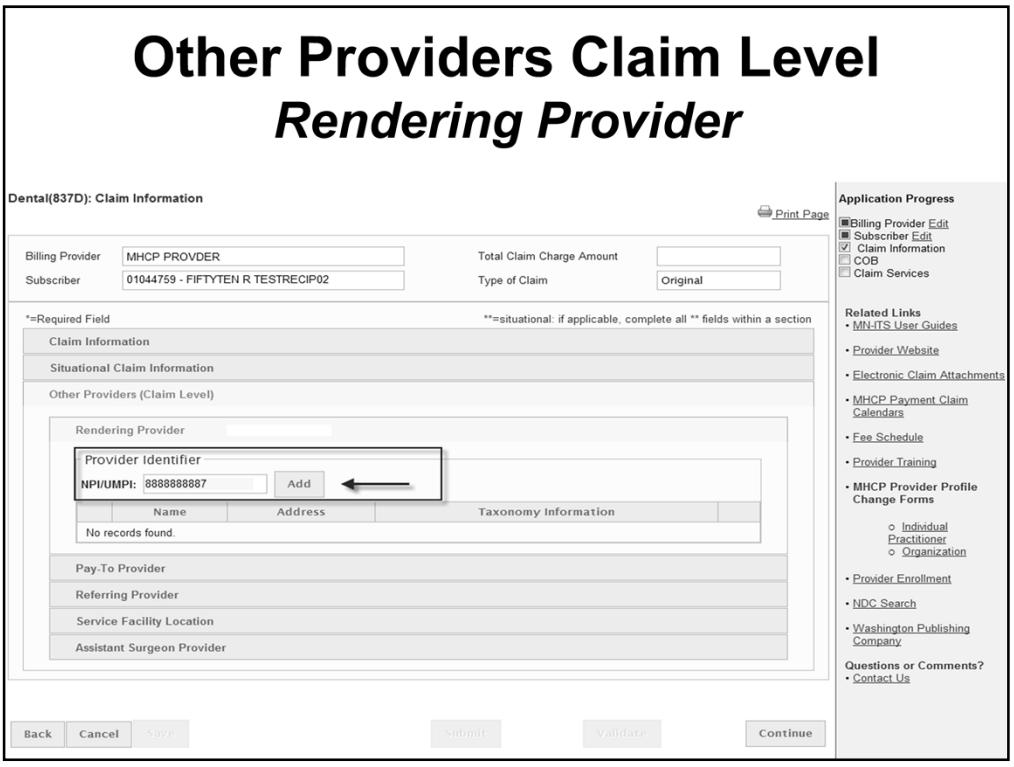
Also include the Date of Accident in the following format DD/MM/YYYY.

Other Providers Claim Level



Now we will select the **Other Providers (Claim Level)** accordion panel.

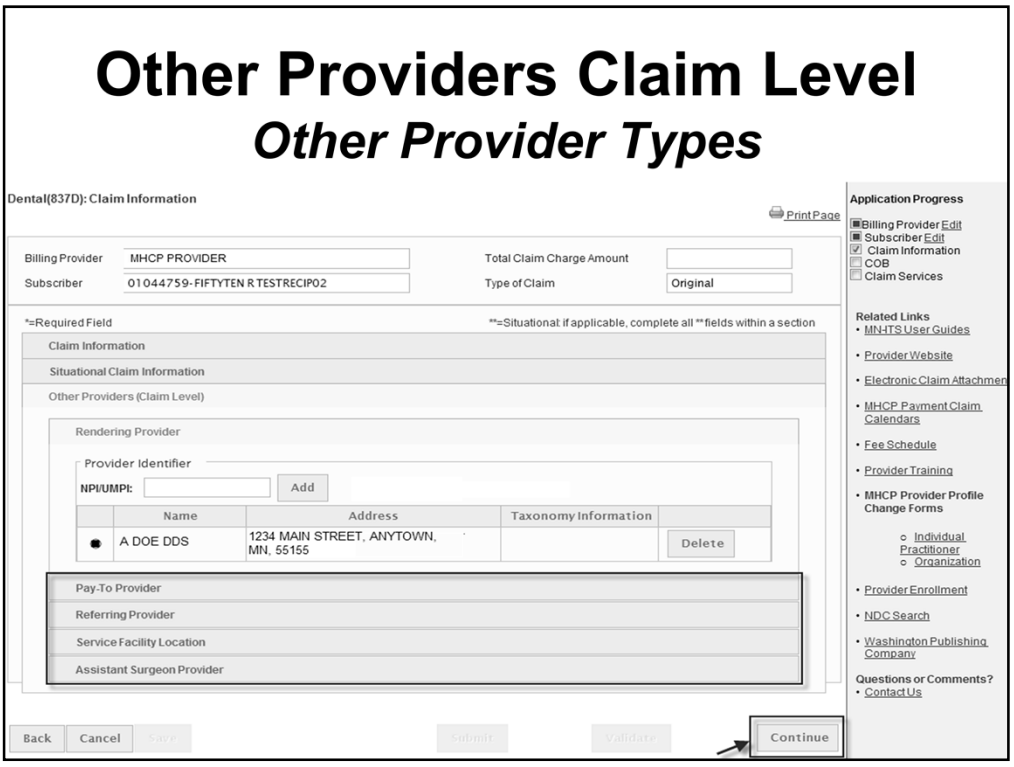
Other Providers Claim Level
Rendering Provider



The other providers claim level opens to the rendering provider subsection. Enter the NPI or UMPI for the Rendering provider and select the **Add** button to save your entry.

Other Providers Claim Level

Other Provider Types

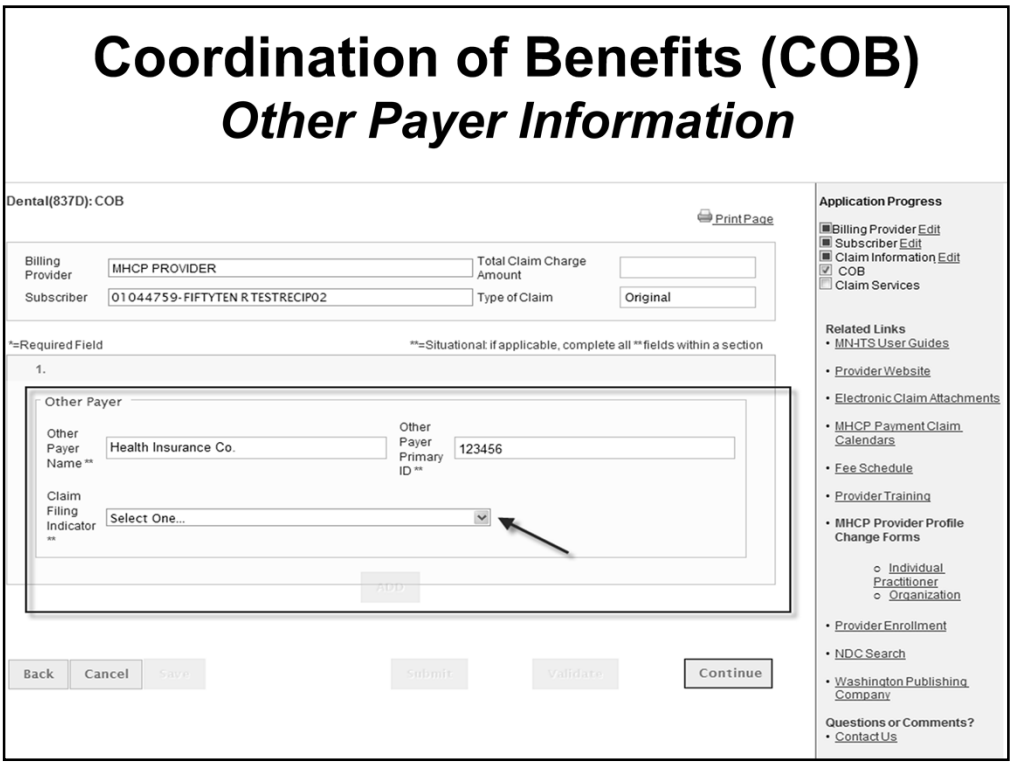


The rendering providers name, address and any taxonomy information that is on file with MHCP will now display. Select the **Radio Button** next to the providers name to save the entry at the claim level.

The **other providers**; Pay-To, Referring, Service Facility Location or Assistant Surgeon may be required depending on the service being preformed. There are subsections for each type of other provider, with their own accordion panel.

Select **Continue** to move on to the COB Screen.

Coordination of Benefits (COB)
Other Payer Information



Use the Coordination of Benefits (COB) screen to report other payer information (also referred to as other insurance or TPL). If you do not need to report other insurance, select the **continue** action button to move to the claim services screen.

Providers are not required to bill MHCP if the other payer(s) paid amount is more than our MHCP allowable. Billers should check with the providers business office on their policy in case there is a business need to submit the claims to properly reconcile your accounts.

The new MN–ITS screens allow providers to submit COB payment and adjustment information at the line level for line by line adjudication. In our example today, we will be showing you what COB fields need to be completed at the claim and line level to receive line level reimbursement.

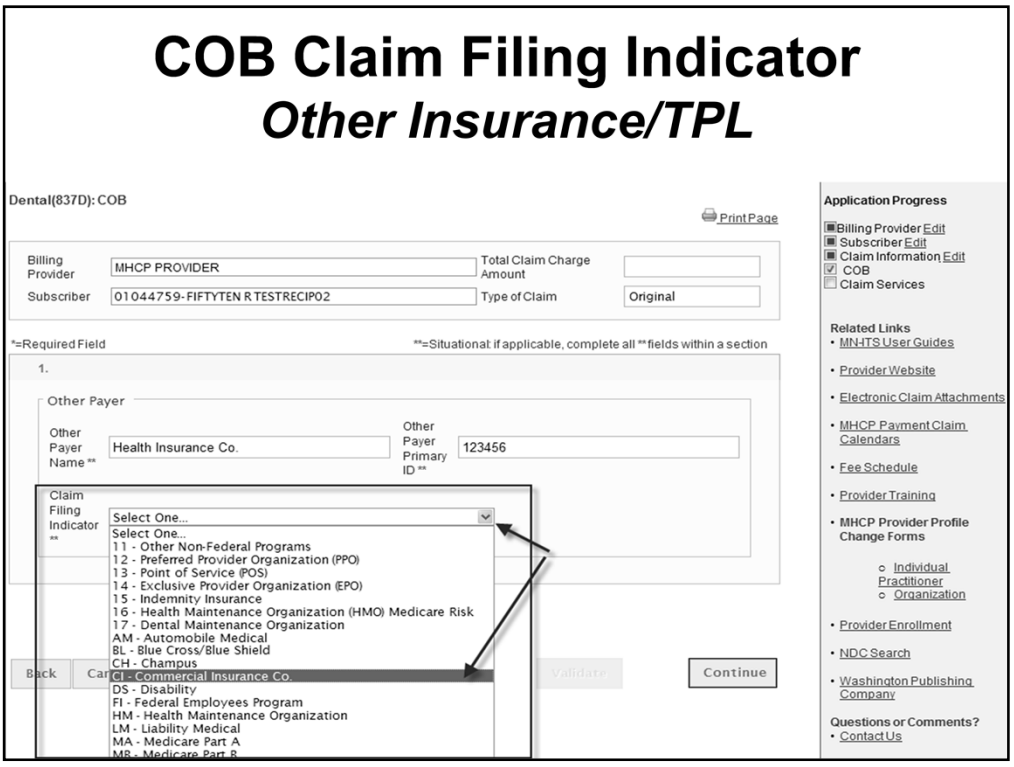
On the COB screen enter the:

- Name of the insurance carrier in the other payer name field
- And the Carrier ID in the other payer primary id field. This number is found on the recipients MN–ITS eligibility response, listed in the other insurance section as the Carrier ID. This 6 digit Carrier ID number is the number you should enter into the other payer primary ID field.

Next we will select a **Claim Filing Indicator** from the dropdown menu that best

describes the type of other insurance.

COB Claim Filing Indicator
Other Insurance/TPL

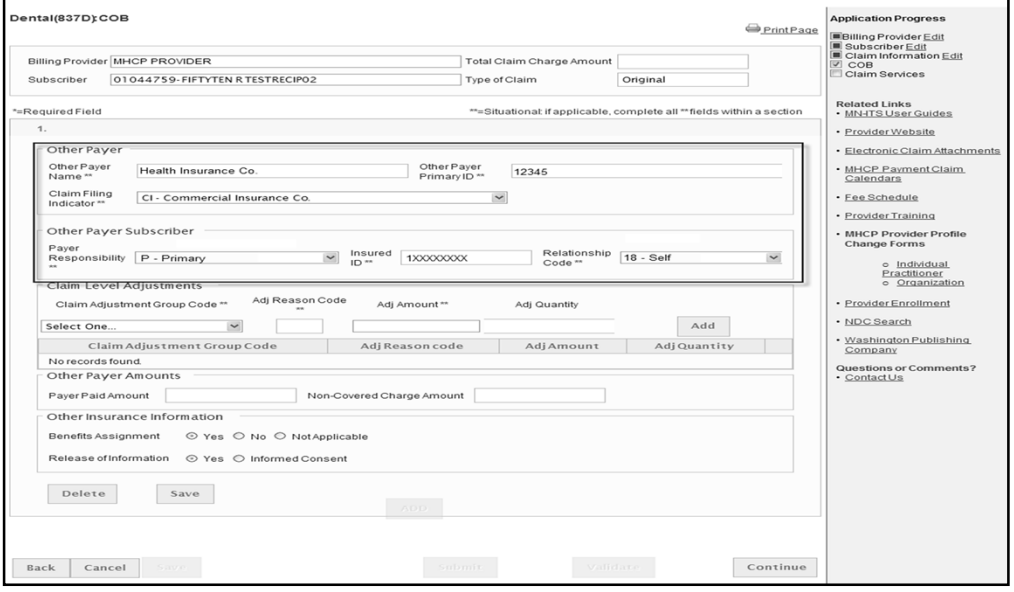


After selecting the dropdown menu, a list of other payer types will display.

Depending on which option you choose in the Claim Filing Indicator field, more fields will display requesting information specific to that type of payer.

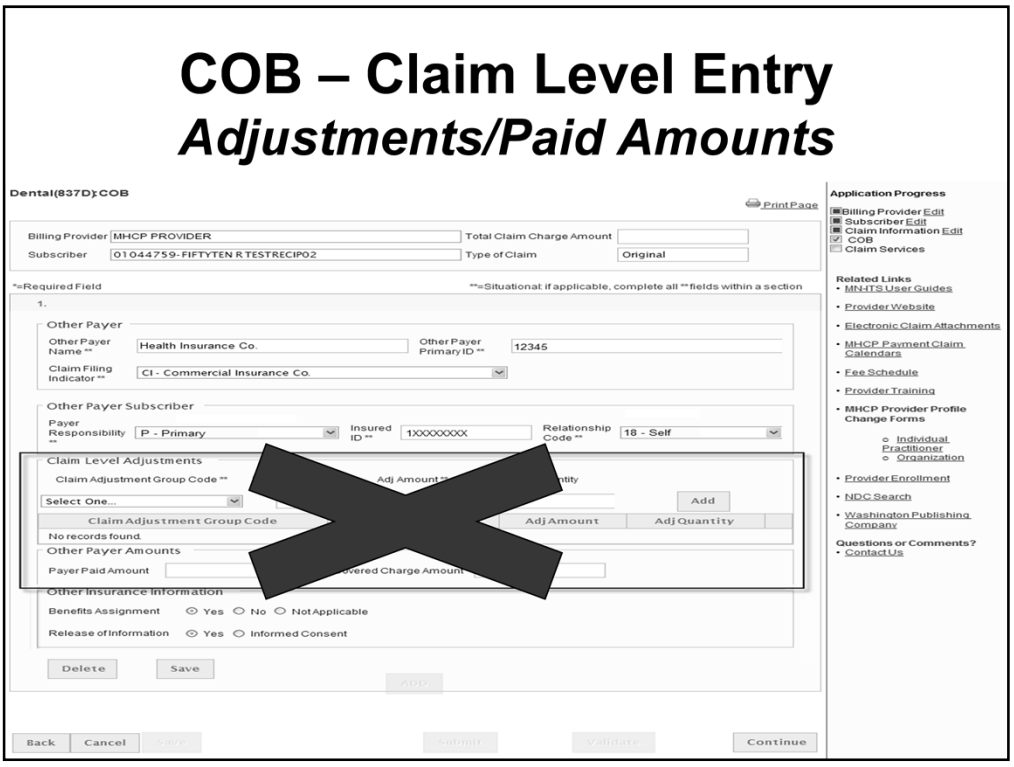
For general insurance coverage select **CI - Commercial Insurance**.

COB – Claim Level Entry
For Line Level Adjudication



A slightly different set of fields, for reporting commercial insurance, now displays. Next we completed the payer responsibility, insured id (which is the policyholder for the other payer) and their relationship code. These field are required at the COB claim level for all providers.

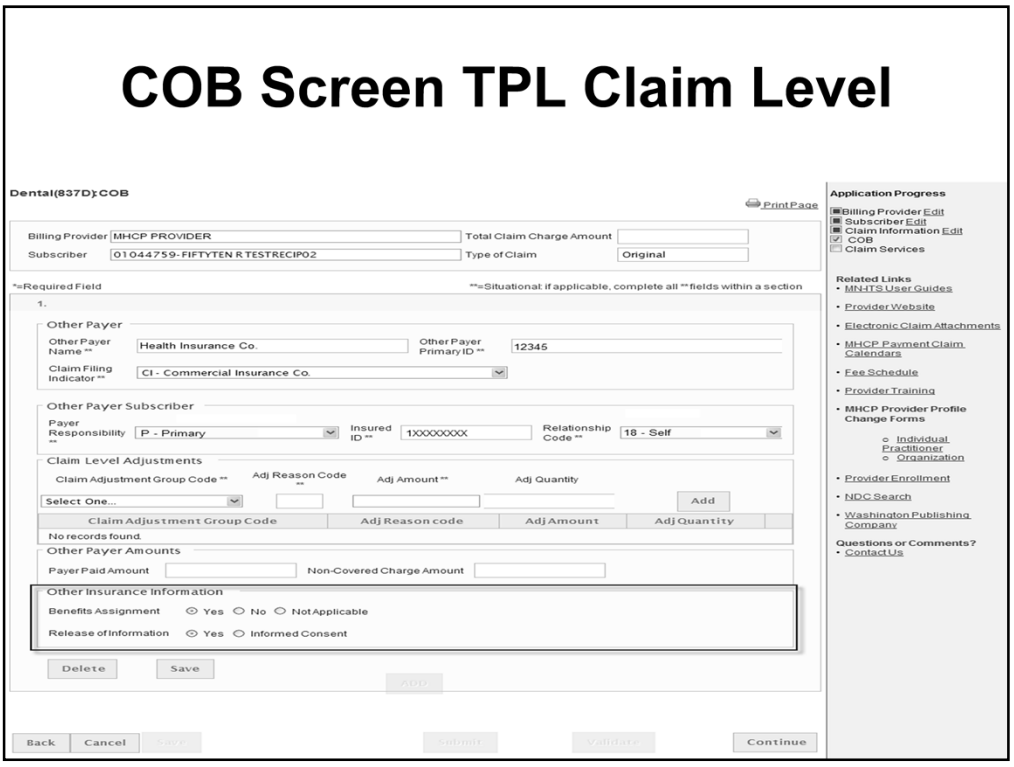
COB – Claim Level Entry
Adjustments/Paid Amounts



Do **not** complete the **Claim Level Adjustments** or **Other Payer Amounts** at the COB claim level. These adjustments will be added at the Service/Line level in the other payer accordion section. Providers who should enter COB at the line level include all dental providers who receive fee-for service reimbursement from MHCP.

Providers who receive an encounter rate should attend the webinar 837D Dental Claim Level COB for the correct instructions on submitting secondary claims to MHCP.

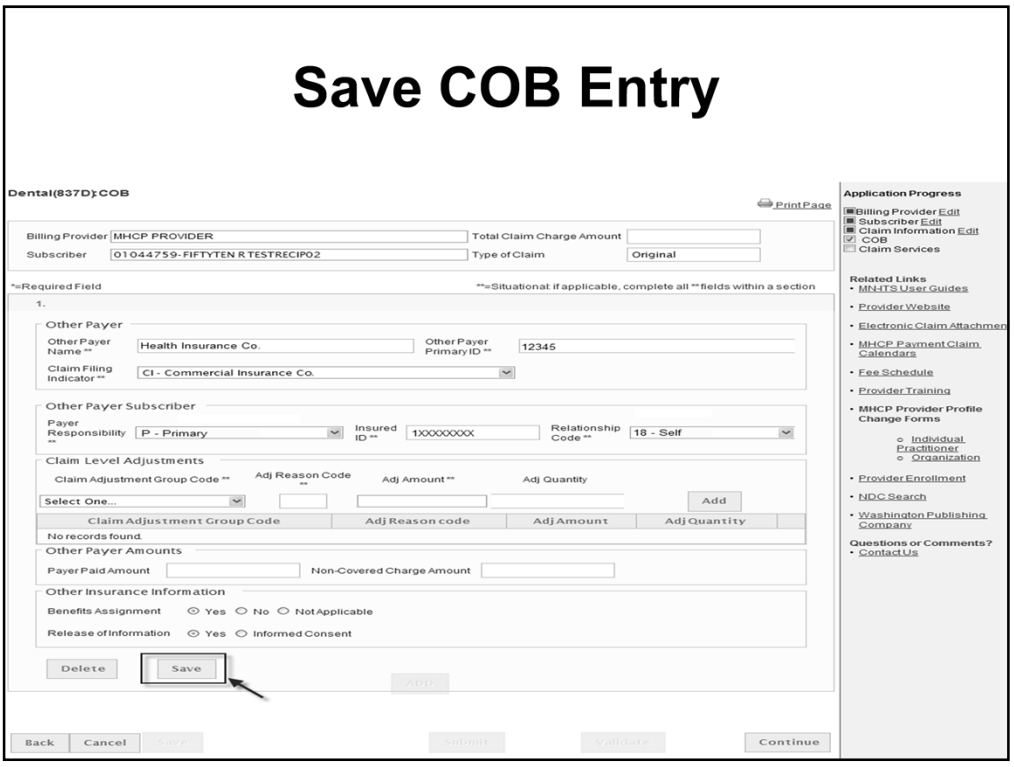
COB Screen TPL Claim Level



Next in the other insurance information fields: benefits assignment and release of information are defaulted with the standard response, **yes**.

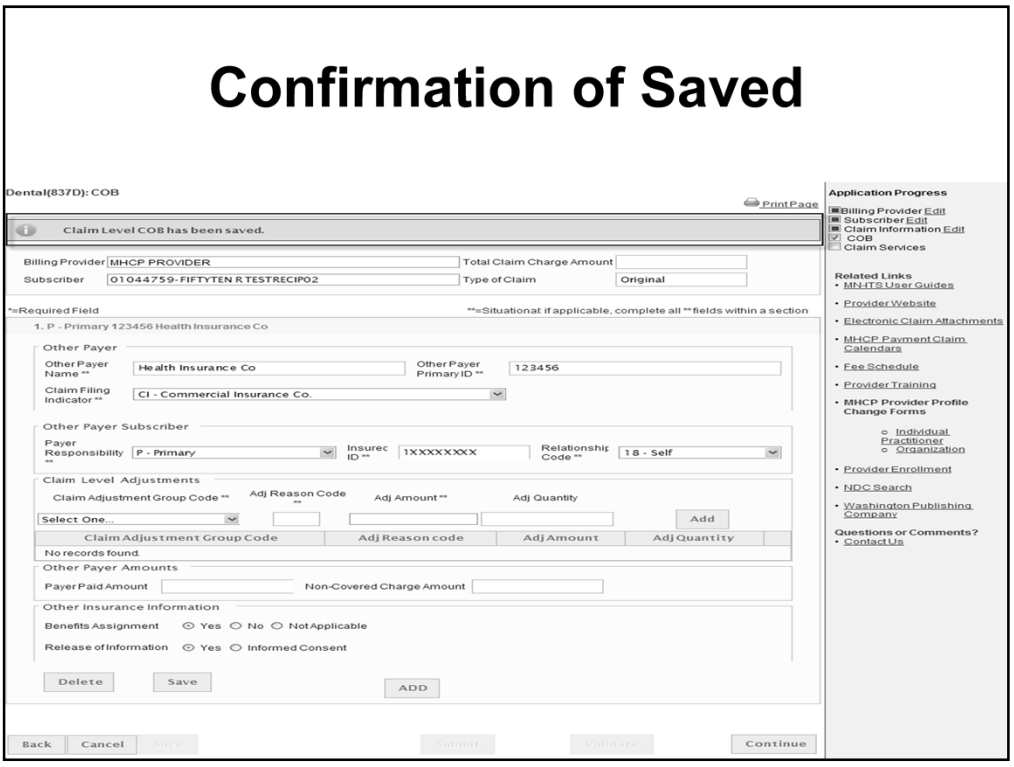
Again, if the default response is incorrect, select the radio button for the response that best describes the actual documentation on file.

Save COB Entry



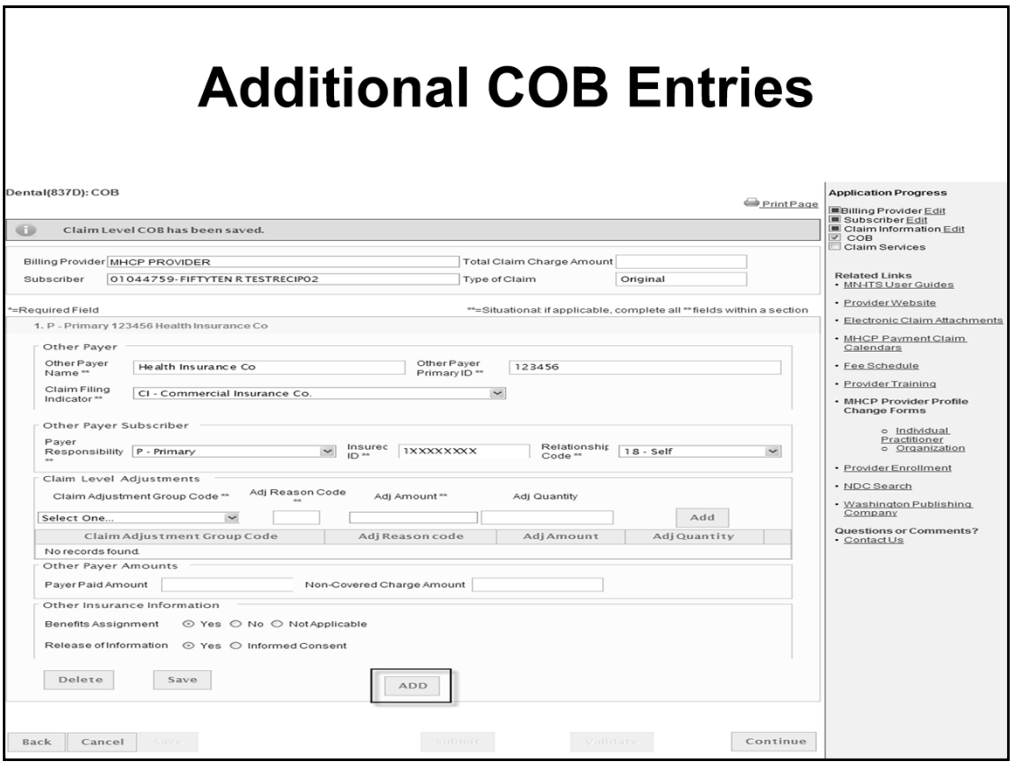
Next you must save your COB entry before continuing. If the entered COB information is not saved, it may not apply to your claim properly. Select **Save**.

Confirmation of Saved



Displayed at the top of the screen, you will now see a message informing you the Claim Level COB has been saved.

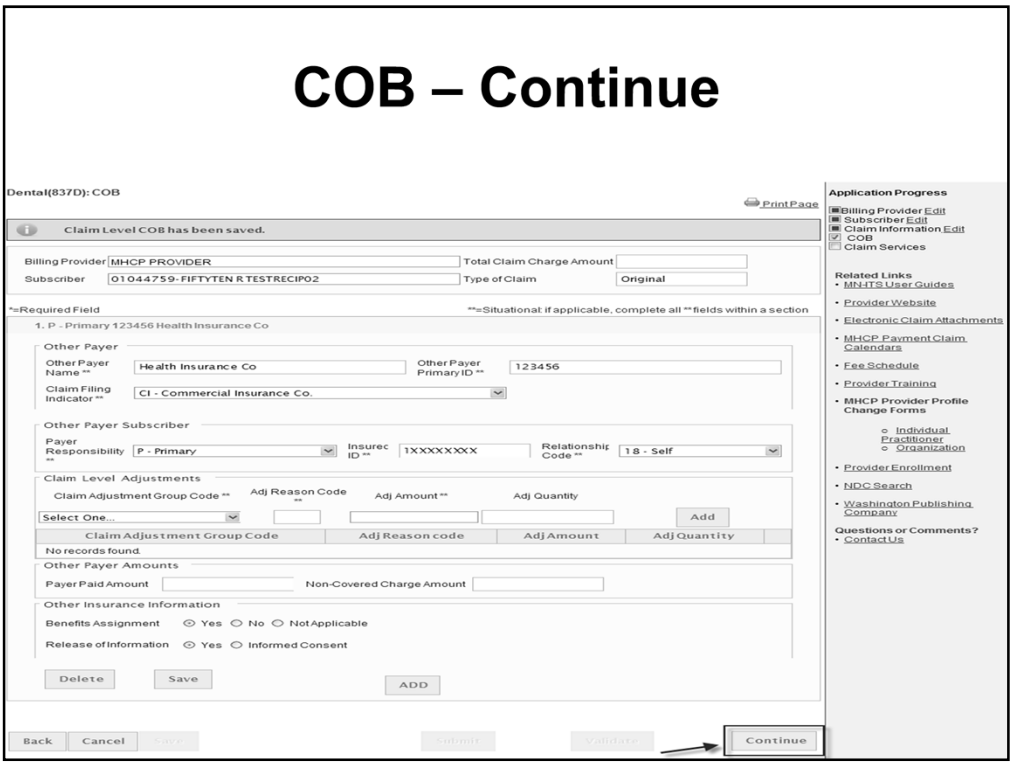
Additional COB Entries



An additional action button **ADD** will now appear. If there is another insurance payer responsible prior to MHCP coverage, you must select the **ADD** action button at the COB Claim level section. Enter the other payer information following the same steps as the first entry and indicate the payer responsibility as secondary.

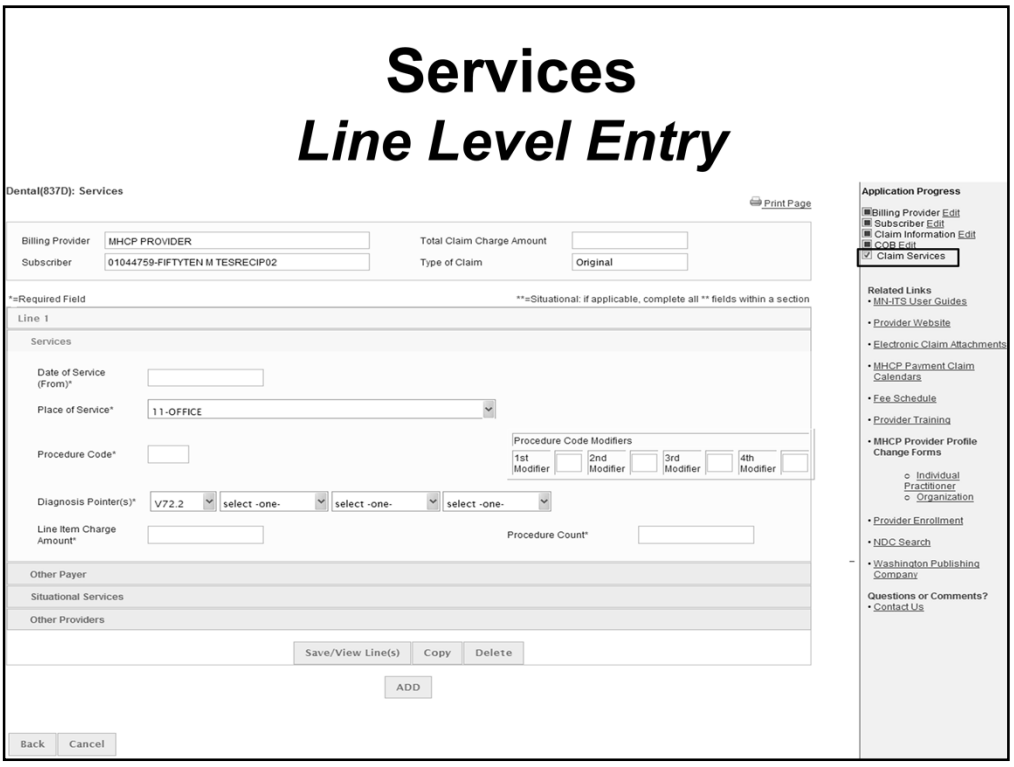
Providers who wish to remove their claim level COB entry can do so by selecting the **Delete** action button.

COB – Continue

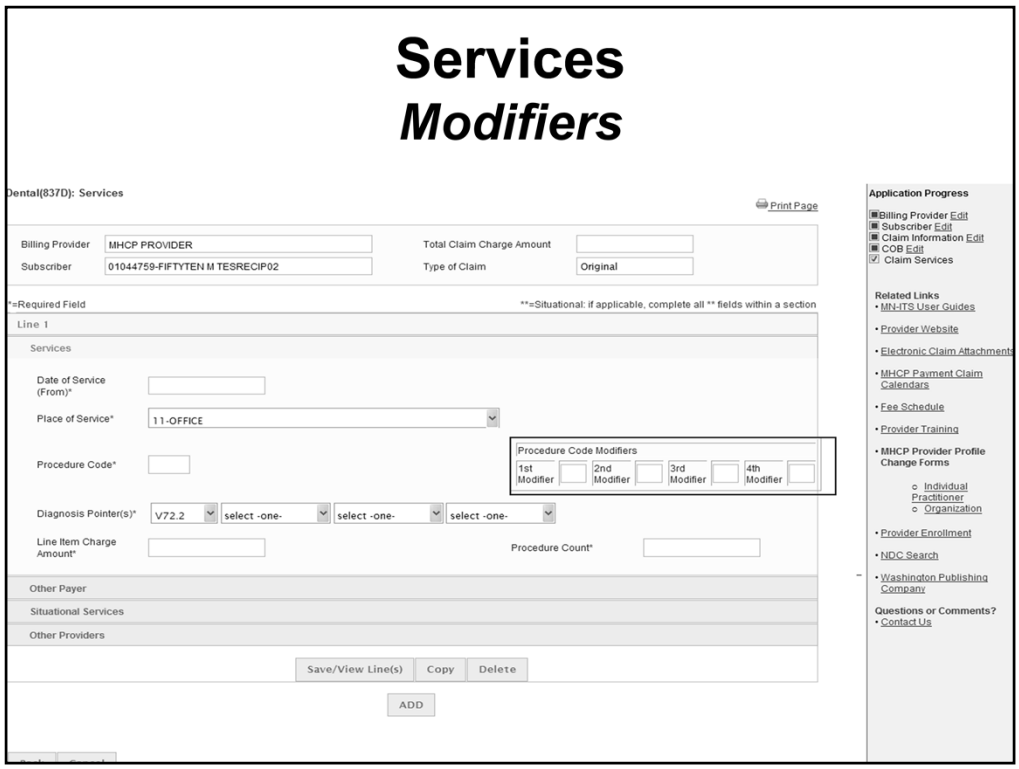


In our example there is only one payer, so we will select **Continue** to move to the Services screen.

Services
Line Level Entry



The accordion panels at the line level are similar to the header or what is called the claim level. On the top right side the Application Progress shows we are now on the Claim Services screen.

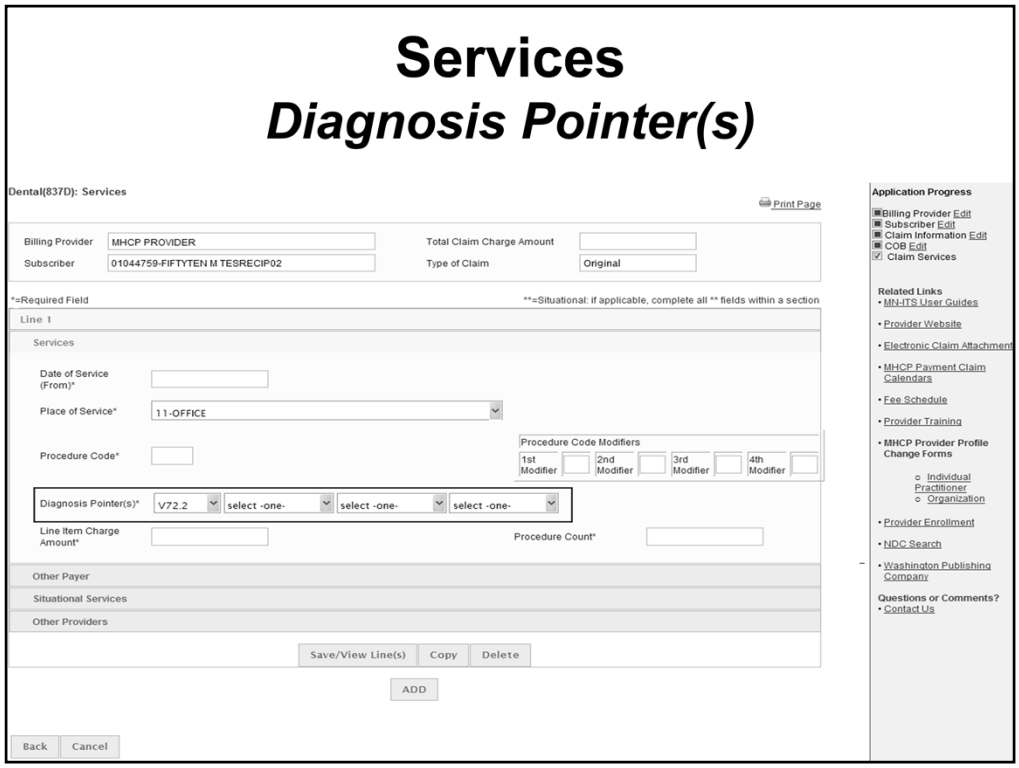


The Services screen contains multiple sections. Again, the section we are in is indicated by the orange title **Services**, and the other sections are collapsed in blue.

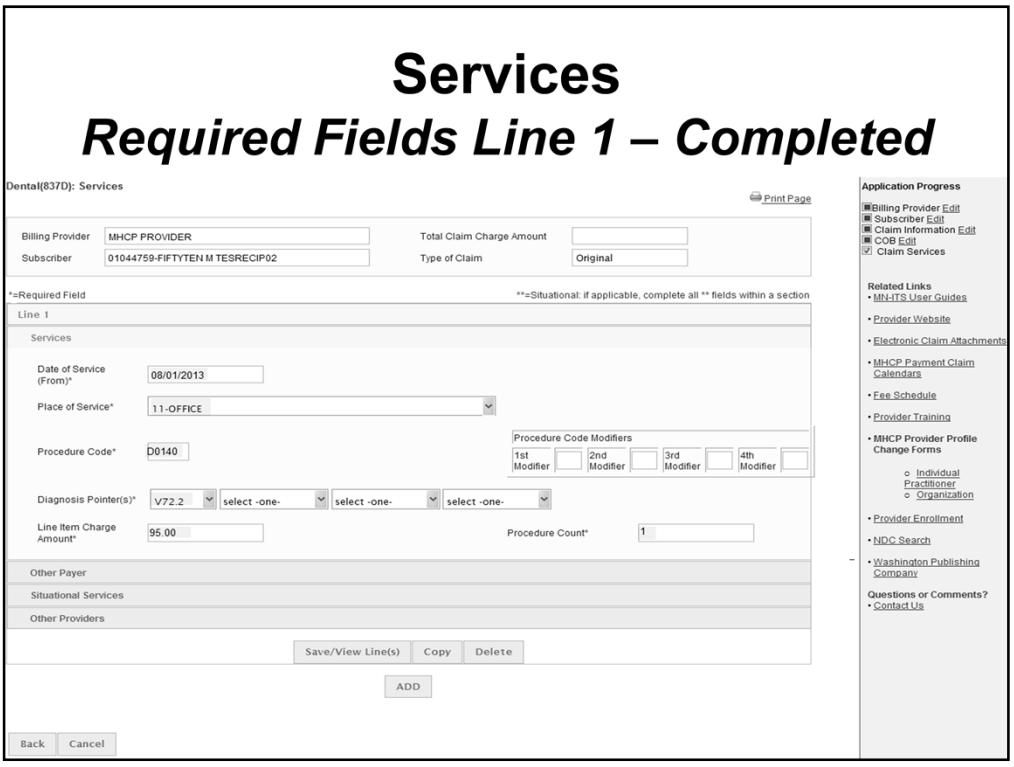
Most fields remain the same, so in our example we will be pointing out the newer fields before we complete a service line example.

Procedure code modifiers display as a table that allows providers to enter up to 4 different modifiers. Currently modifiers are not required for the MHCP dental claim transaction.

Services
Diagnosis Pointer(s)



The diagnosis pointers appear in a table that displays up to 4 different ICD9 diagnosis codes. The first diagnosis field is auto-populated from the claims information screen with V72.2 , which is the defaulted diagnosis. If additional diagnosis codes were entered at the claim level, the defaulted diagnosis will appear in each of the fields. You can change the defaulted diagnosis in any position by selecting the drop down menu to display the list of available codes. Select the most appropriate diagnosis code for the service line you are entering.



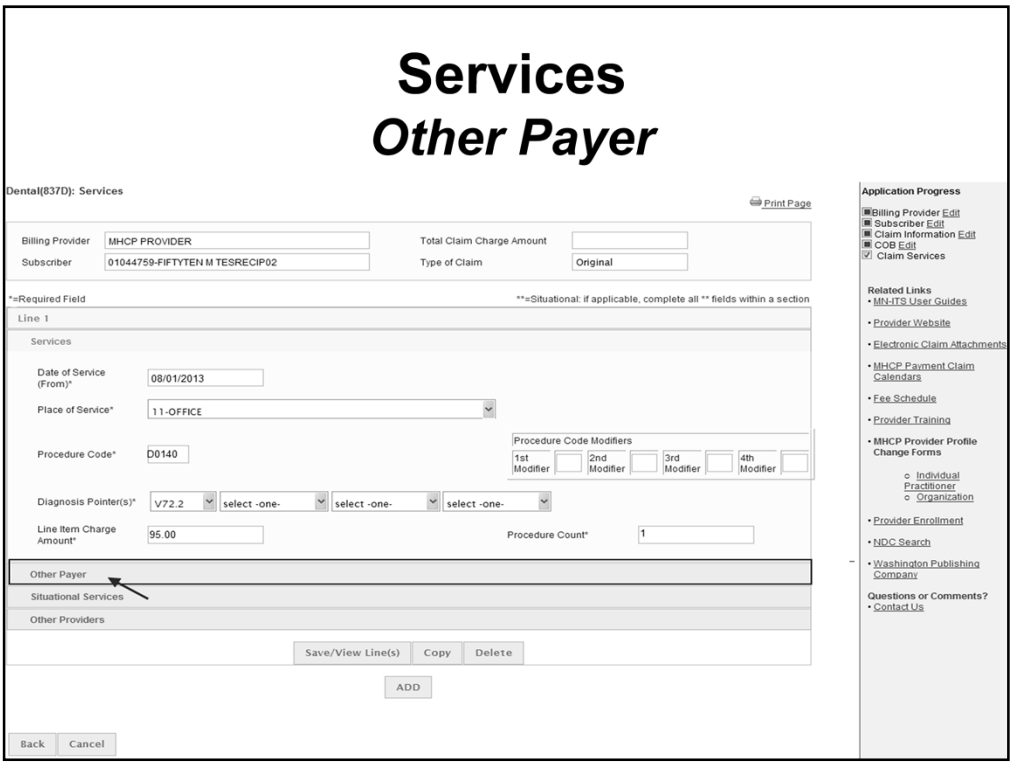
The following required fields are now entered on the Services screen for line one:

- Date of service
- Place of service
- Procedure code
- Diagnosis Pointer and
- Procedure Count

Remember, the Procedure Count for all CDT dental codes is one.

For FQHC, RHC or IHS Providers billing for a Fee-for service recipient enrolled major program BB who is receiving services for a partial denture or full denture; bill using the following instructions:

- For services prior to the delivery of the prosthesis bill using D5899 as the procedure code. Claims staff will refer to your claim note that was entered on the claims situational services screen
- For the actual delivery of the prosthesis; bill using the appropriate partial or full denture code

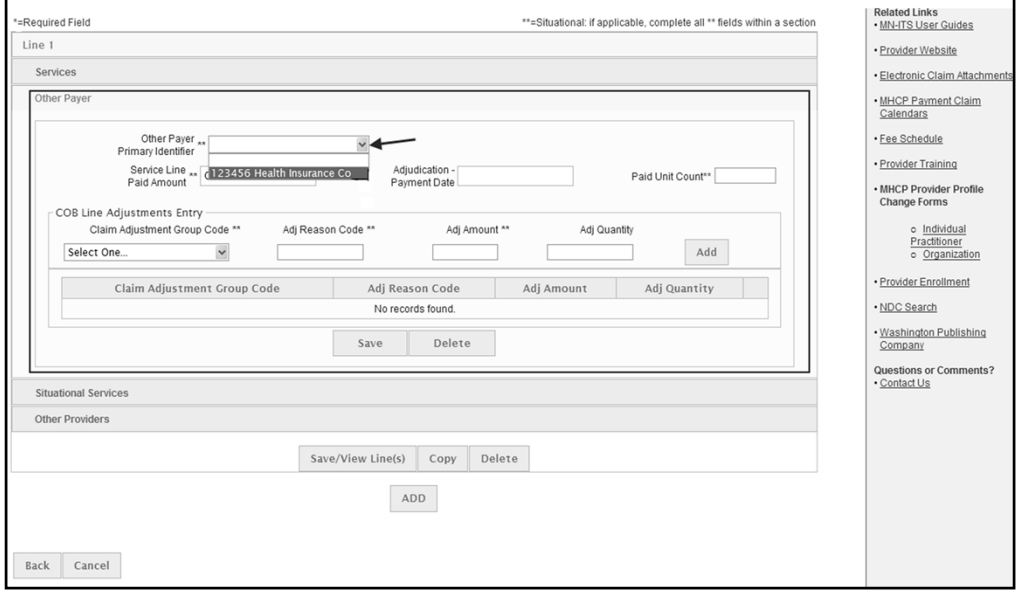


Dependent on the services your are submitting you may need to complete one or more of the other service level accordion sections before saving your line level entry.

If your claim does not include other insurance you can skip the Other Payer accordion section.

Our example includes other insurance, so we will select the **Other Payer** accordion panel to open the next section.

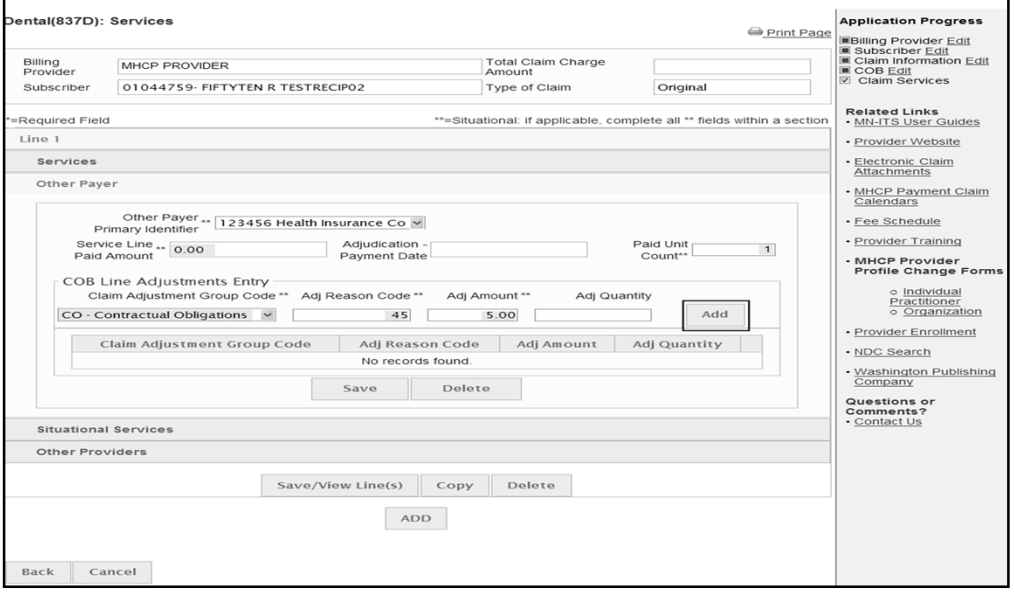
COB TPL Line Level
Other Payer Primary Identifier



The other payer screen allows you to enter COB at the line level by entering the other payers line level adjustments and the amount they paid for each individual line.

First, use the other payer primary identifier drop down menu to select the **other payer ID and name** for the payer that was entered on the COB screen.

Other Payer – Line Level
Paid Amount & Adjustment

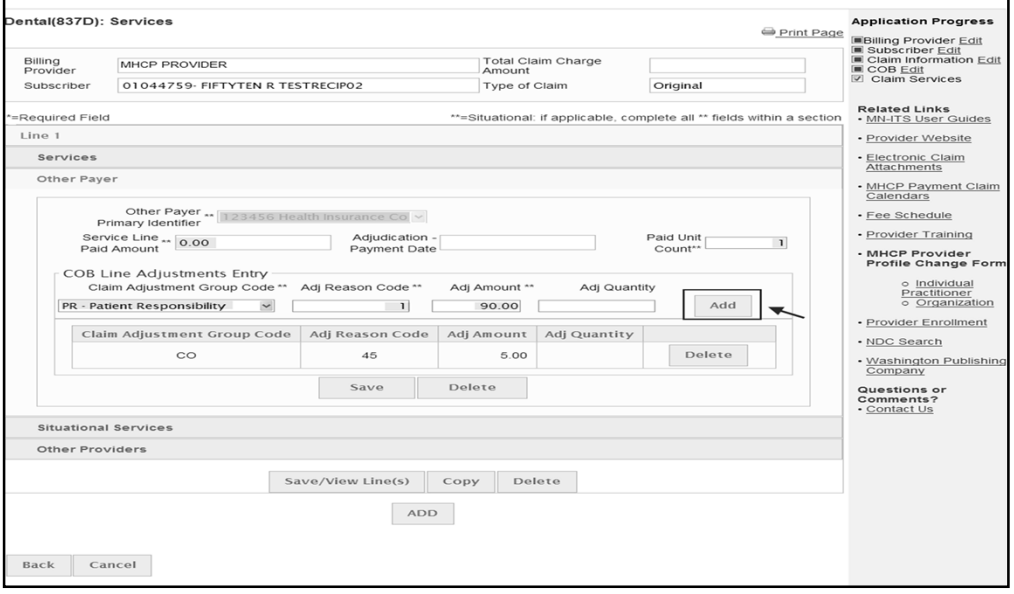


Refer to the other payer's explanation of benefits (or EOB) as you will need to enter the Claim Adjustment Reason Codes and the associated Adjustment amounts.

If their EOB does not include HIPPA compliant reason codes, refer to the Washington Publishing Companies Website on the right navigation menu to review the list of claim adjustment group and reason codes available. Providers can easily access the link to WPC code lists during their claim submission.

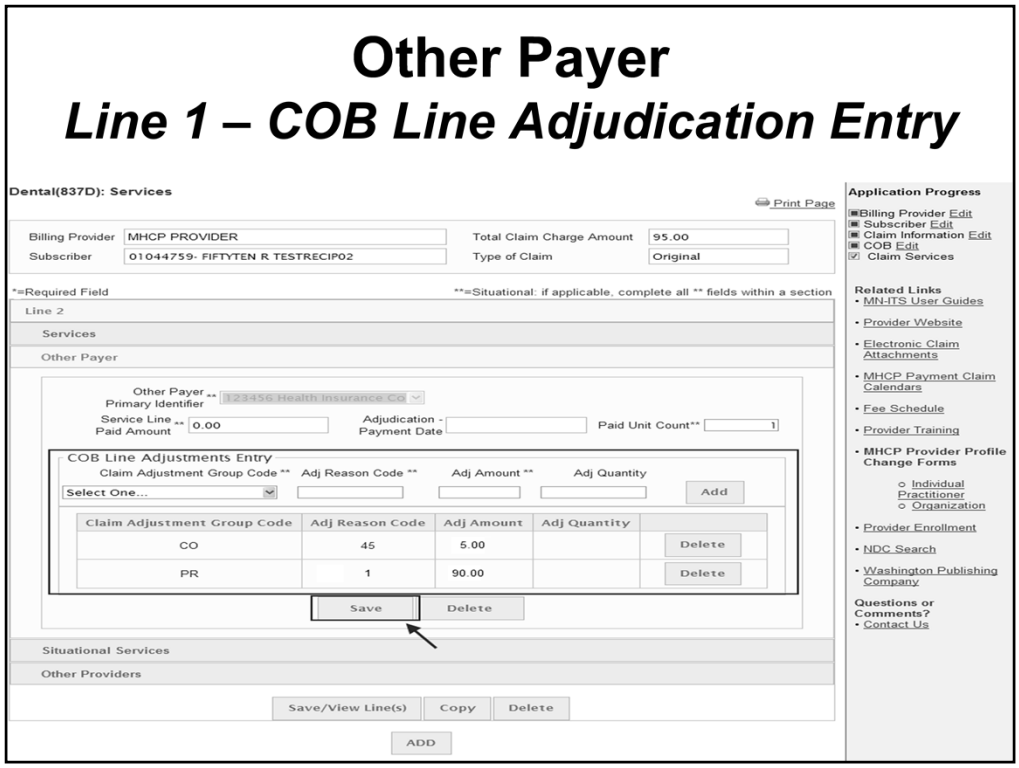
In the Service line paid amount enter the amount that the other payer paid on this individual line. If they paid zero, enter 0. Paid unit count should always be 1. in the COB line adjustments entry subsection we selected from the drop-down menu CO = contractual obligation, the corresponding reason code 45 and the amount of the provider write-off $5.00. Select **Add** to save the entry.

Other Payer – Line Level
Paid Amount & Adjustment Cont.



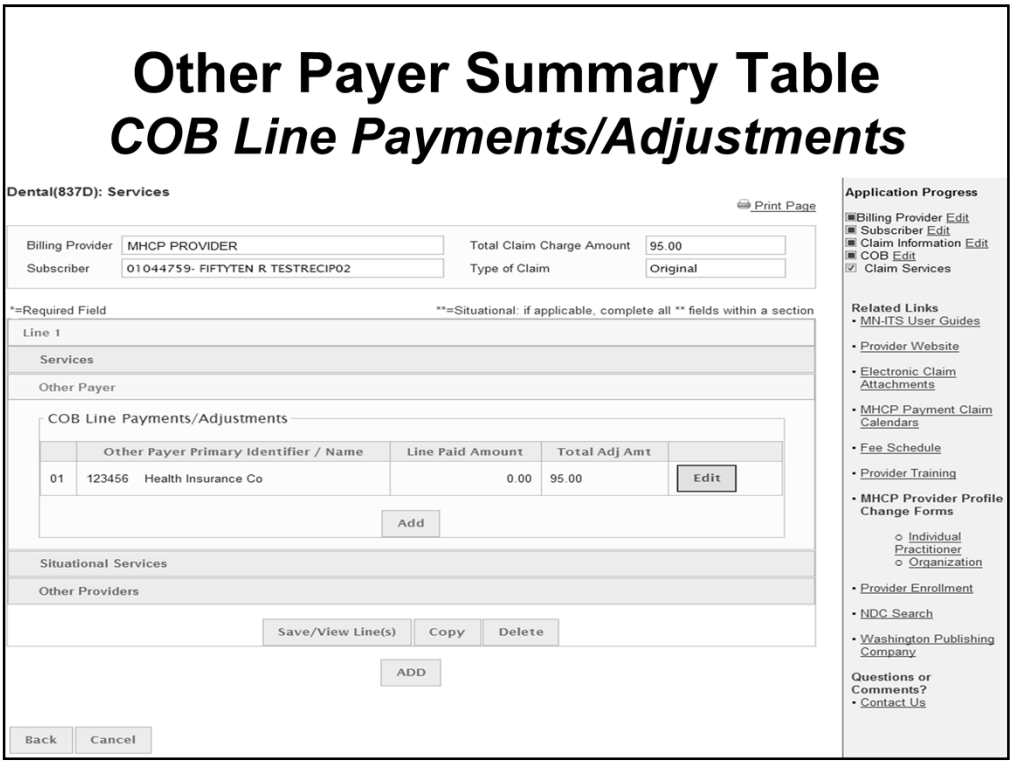
The first COB line adjustments entry for line one displays in a table. For the second adjustment in the COB line adjustments select from the drop-down menu PR = patient responsibility, the corresponding adjustment reason code 1 = deductible and the amount applied to the deductible $90.00. Select **Add** to save the entry.

Other Payer
Line 1 – COB Line Adjudication Entry



Verify all of the other payers paid amounts and adjustments that display in the COB table for this service line have been entered. If all entries have been made, select the **Save** action button directly below the COB table.

Other Payer Summary Table
COB Line Payments/Adjustments

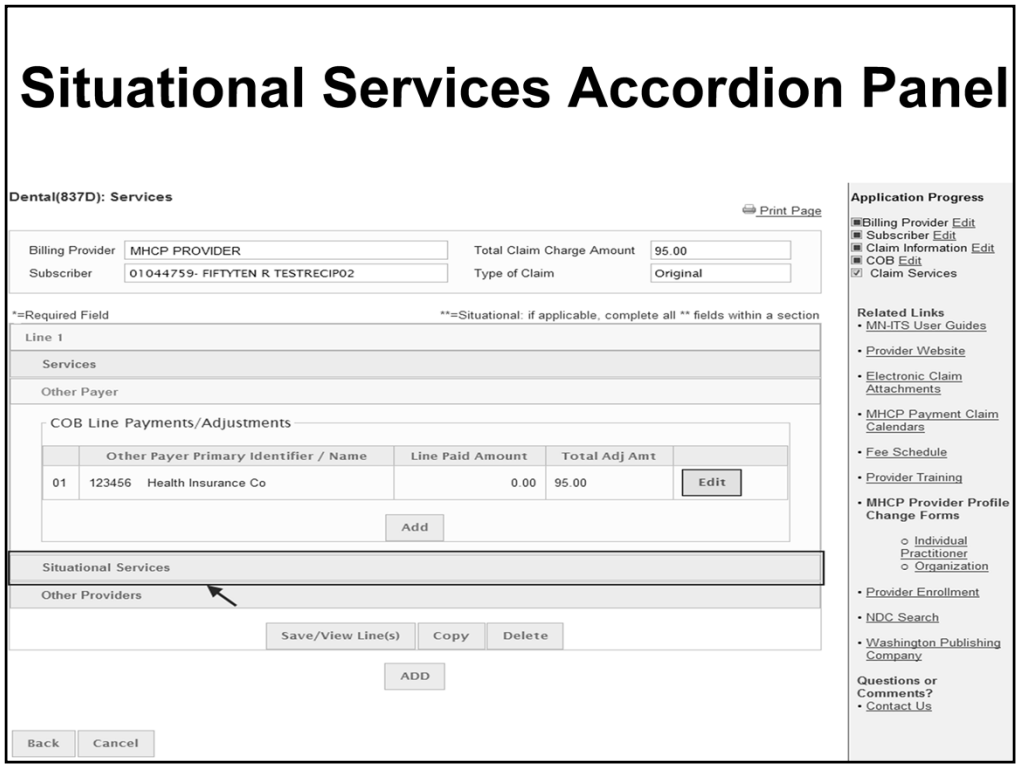


A summary displays the total COB line payments/adjustments that were entered for line one. It is **important** that the line/paid amount and the total adjustment amounts equal the individual lines submitted charge.

The total submitted charge for line one equals 95.00; and the total payment and adjustments amount equals 95.00. If the amounts did not equal the claim line would deny for being out of balance.

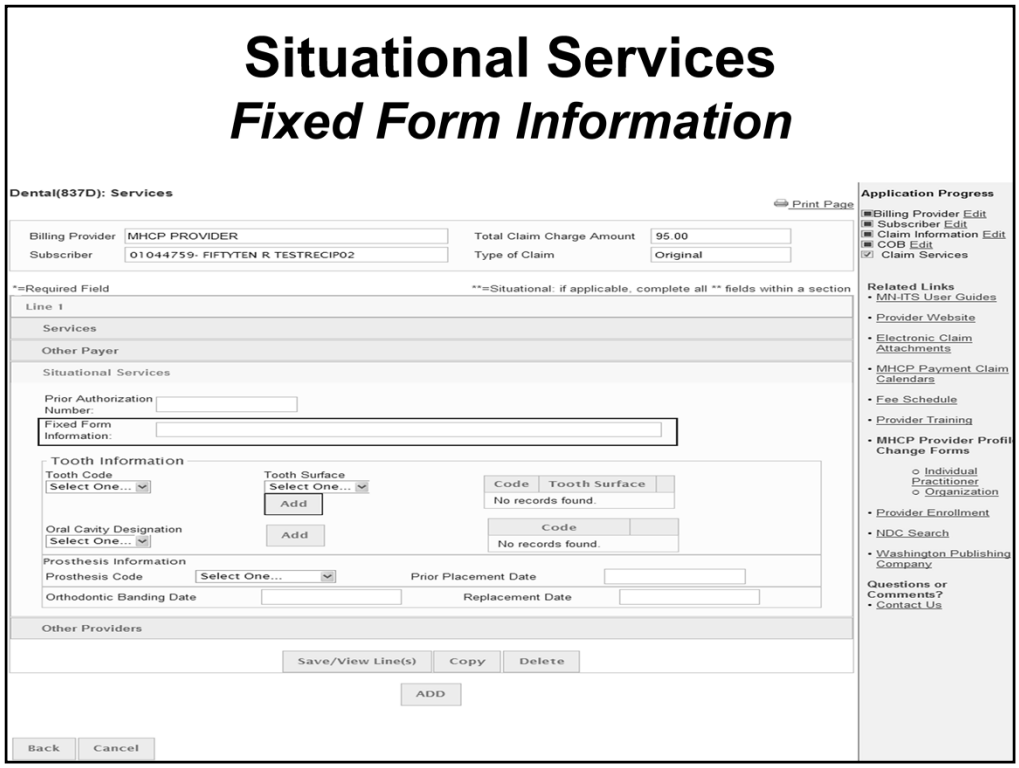
To change or review the information, select **Edit** from the COB line payments/adjustments summary table to return to the other payer line level COB entry. If there was an additional other payer entered at the COB Header/Claim level, select the Add action button to enter COB line payment and adjustment for this line. In our example there is only one payer.

Situational Services Accordion Panel



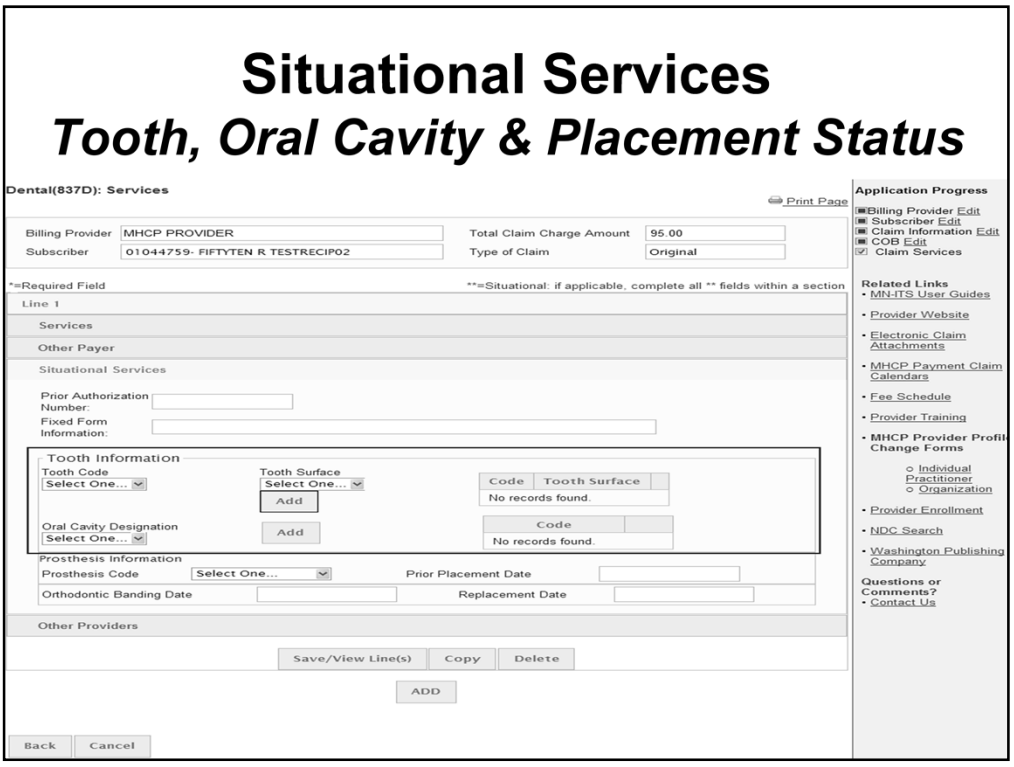
Select the **Situational Services** accordion panel.

Situational Services
Fixed Form Information



One of the new fields on the situational services screen is the Fixed Form Information field. At this time this field is not required on the dental claim.

Situational Services
Tooth, Oral Cavity & Placement Status



Dependent on the services your are submitting you may need to complete some of the other situational services fields. The Tooth information section is used to report tooth numbers and surfaces, or oral cavity designations as appropriate.

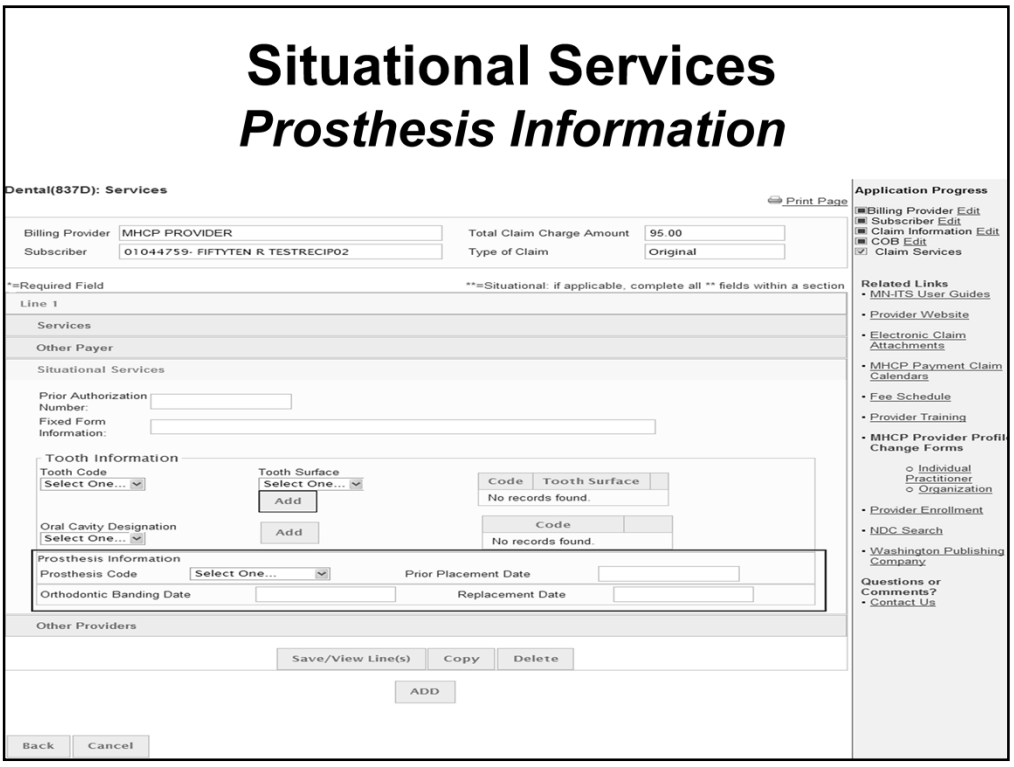
For a service with multiple tooth surfaces; providers must select the tooth number and the single surface, then select the **Add** button. Providers **must** repeat this process until each surface has been added.

MHCP will process all surfaces reported for that one tooth number as one service line. Providers can not report more than one tooth number on a service line.

For a service with multiple oral cavity designations; providers must select the oral cavity designation code, then select the **Add** button. Providers **must** repeat this process until each oral cavity designation code has been added. Again MHCP will process all codes reported as one service line.

Tooth numbers or oral cavity designations should not be reported on claims for partials or dentures.

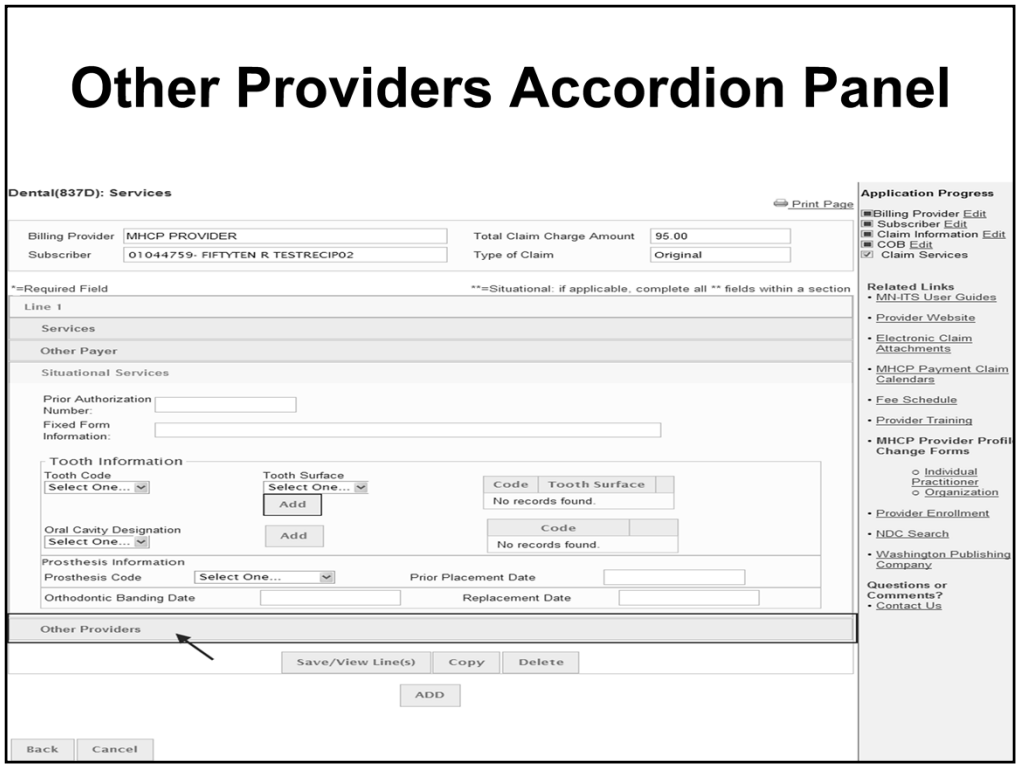
Situational Services
Prosthesis Information



The remaining sub-section allows provider to enter the:

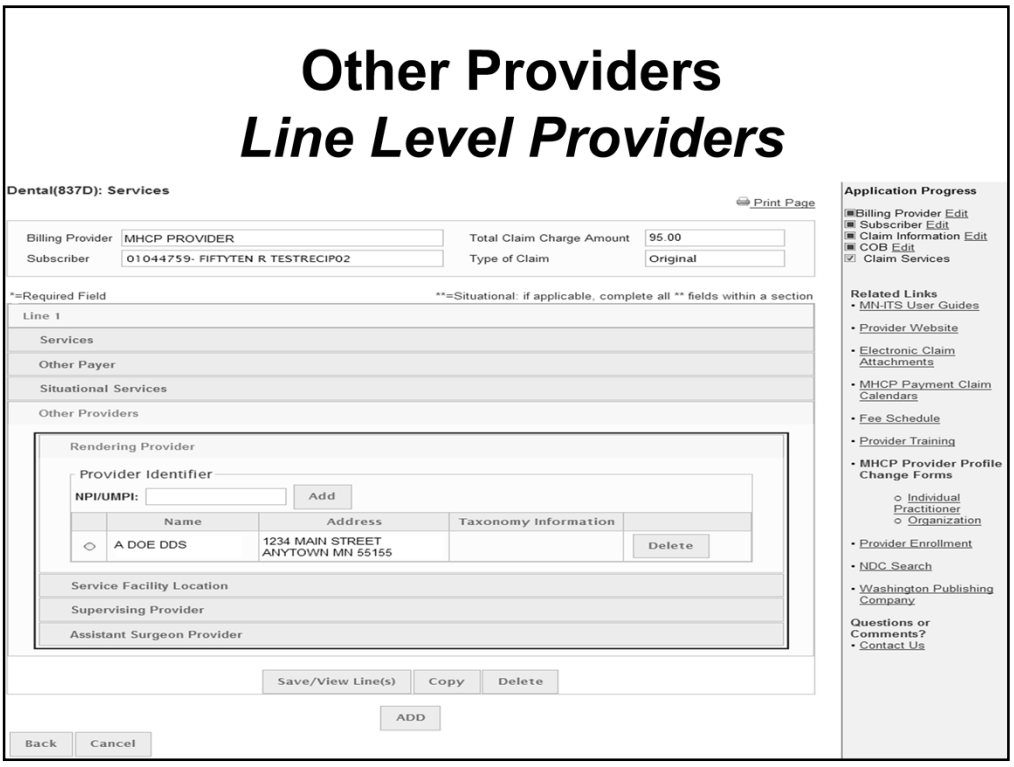
- Prosthetic code that indicates if the appliance is an Initial or replacement prosthesis; and the prior placement date
- Date of the orthodontic banding
- Orthodontic appliance replacement date

Other Providers Accordion Panel



Select the **Other Providers** accordion panel.

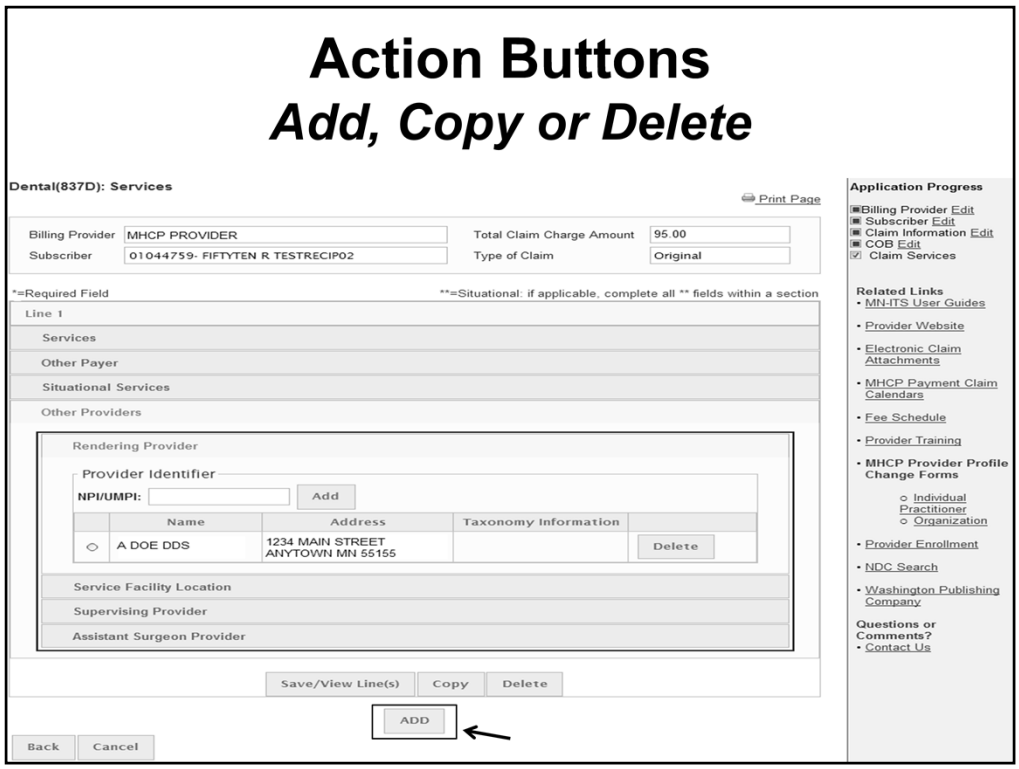
Other Providers
Line Level Providers



The other providers screen opens displaying the rendering provider that was entered and selected at the claim level. You do not have to make any entries or changes to the line. If this is the provider who rendered the service.

If you need to identify a different rendering provider for this service line, enter that providers NPI or UMPI, then select the **Add** button and next select the **Radio Button** to save the new entry. Entries made at the service line level will override what was entered at the claim level.

To add one of the other provider types Service Facility Location, Supervising Provider or Assistant surgeon to your service line, select the appropriate closed accordion panel, enter the NPI or UMPI for the provider, and again select the **Add** button and then select the **Radio Button** to save the entry.



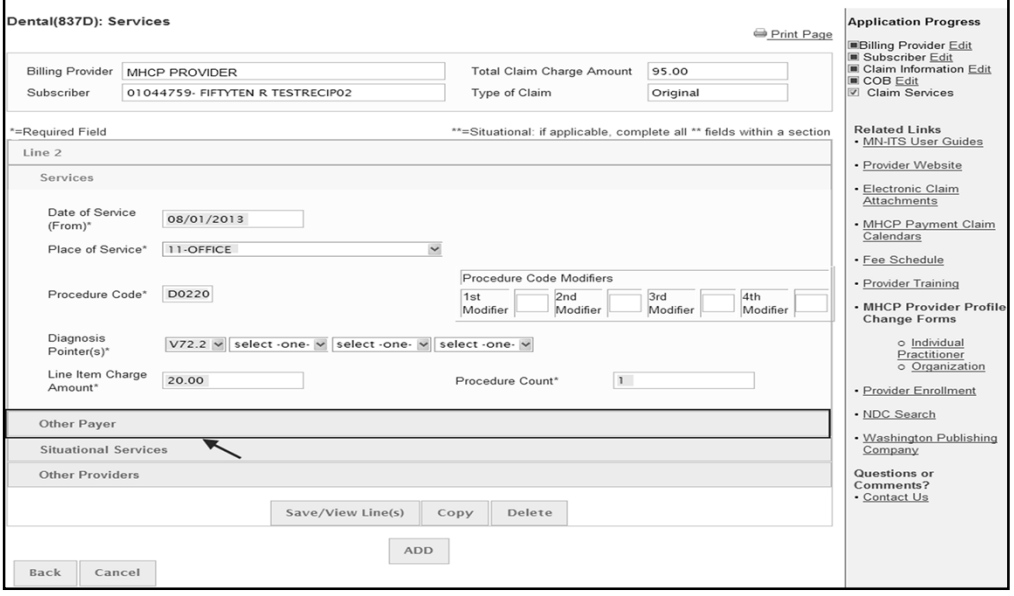
On the new MN–ITS screens there will be two ways to create a new service line:

1. Selecting **Copy** creates a new service line that automatically duplicates the same information as the current line you just completed. (Remember if you entered other payer, situational services or an other provider on the line you are copying, you will need to re-verify those entries are correct for this new line you will be submitting).
2. Selecting **ADD** will display an entirely new service line that will display with blank fields ready for you to enter.

The **Delete** action button will completely remove all entries that were made for line one.

In our example we will select **ADD** to create a new blank line.

Services Screen
Required Fields Line 2 – Completed

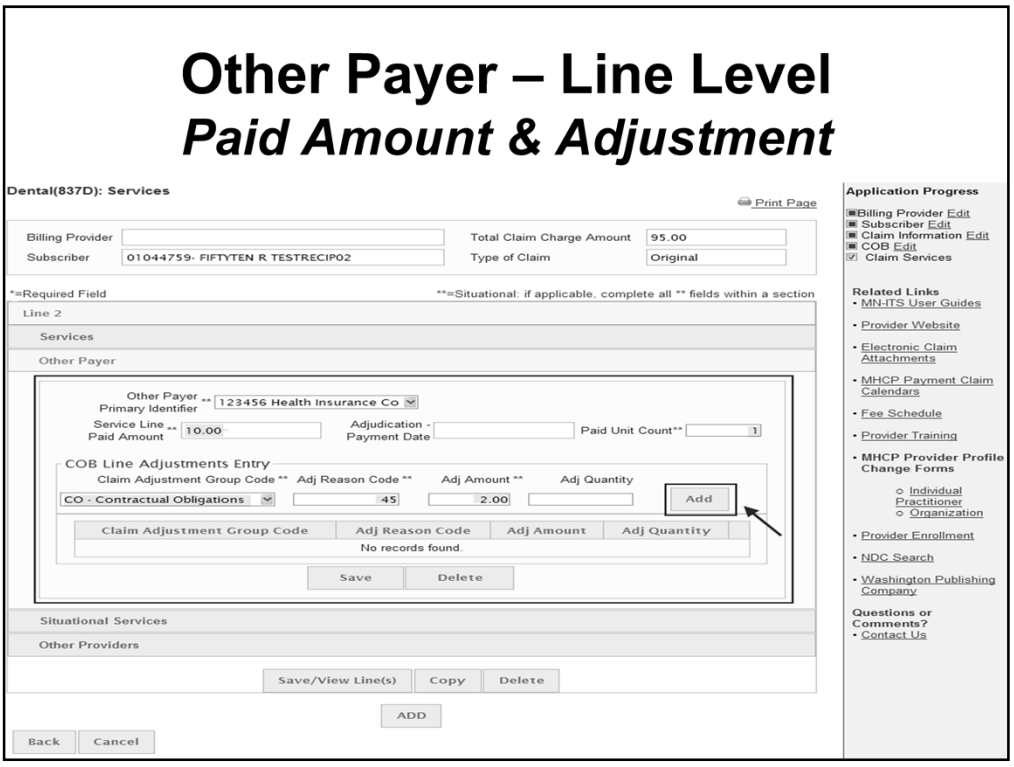


For line two we have entered the following required fields:

- Date of service
- Place of service
- Procedure code
- Diagnosis Pointer
- And a Procedure Count

Next we will select the **Other Payer's** Accordion Panel to add the COB information for line 2.

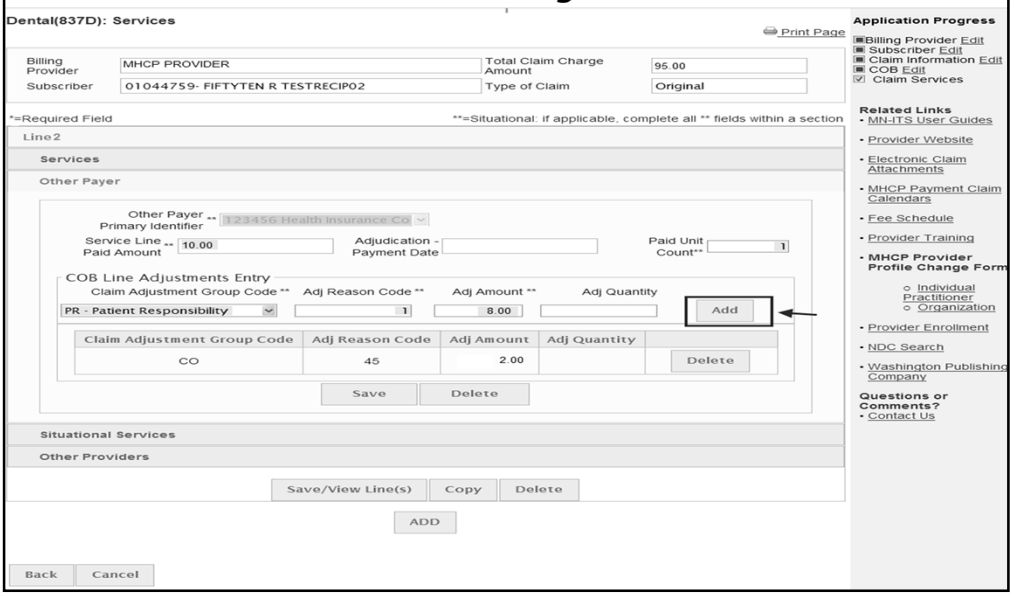
Other Payer – Line Level
Paid Amount & Adjustment



Again, refer to the other payer's explanation of benefits (or EOB) you will need to enter the Claim Adjustment Reason Codes and the associated Adjustment amounts. If their EOB does not include HIPPA compliant reason codes, refer to the Washington Publishing Companies Website Reference tab to review the list of codes available.

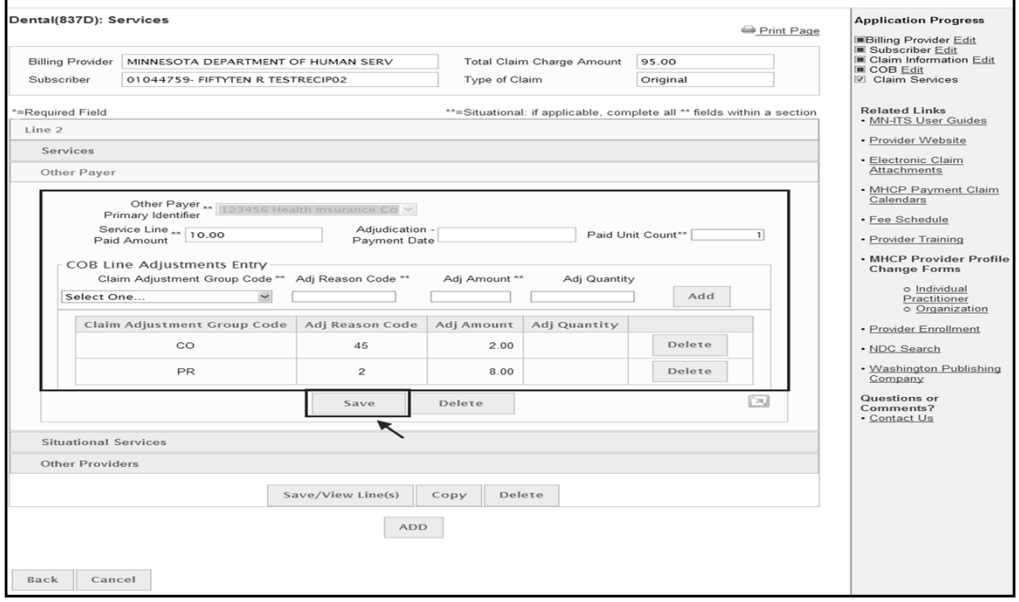
In the service line paid amount enter the amount that the other payer paid on this individual line, they paid $10.00. Paid unit count should always be 1. Next in the COB line adjustments entry fields we selected CO (contractual obligation) from the drop-down list, the corresponding reason code 45 and the amount of the provider write-off $2.00. Select **Add** to save the entry.

Other Payer – Line Level
Paid Amount & Adjustment Cont.



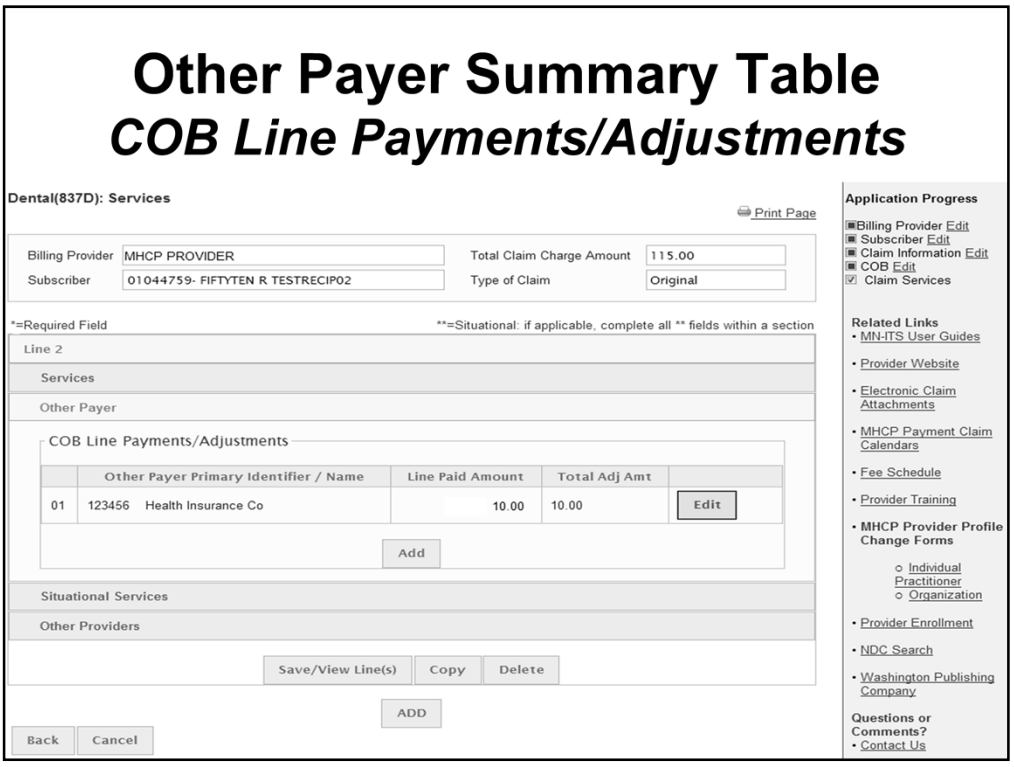
The first entry for line two displays in a table. Next from the COB line adjustments entry drop-down we select PR (Patients Responsibility) and enter adjustment reason code 1 (deductible) and adjustment amount $8.00. Select **Add** to save the entry.

Other Payer
Line 2 – COB Line Adjudication Entry



Verify all of the other payers paid amounts and adjustments for this service line have been entered. If all entries have been made, and select the **Save** action button to display the COB table that calculates the total amounts that were entered for line two.

Other Payer Summary Table
COB Line Payments/Adjustments

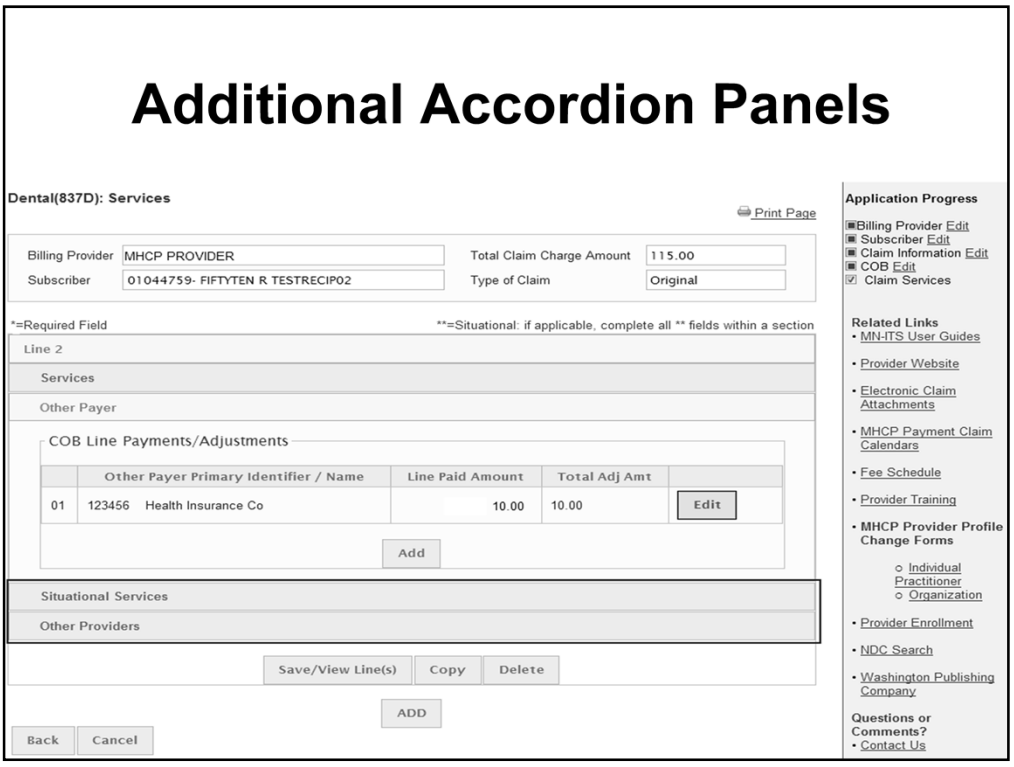


A summary of the Other Payer payments and adjustments will display in a table. Again, make sure the line/paid amount and the total adjustment amounts equal the individual lines charge or they will deny for being out of balance.

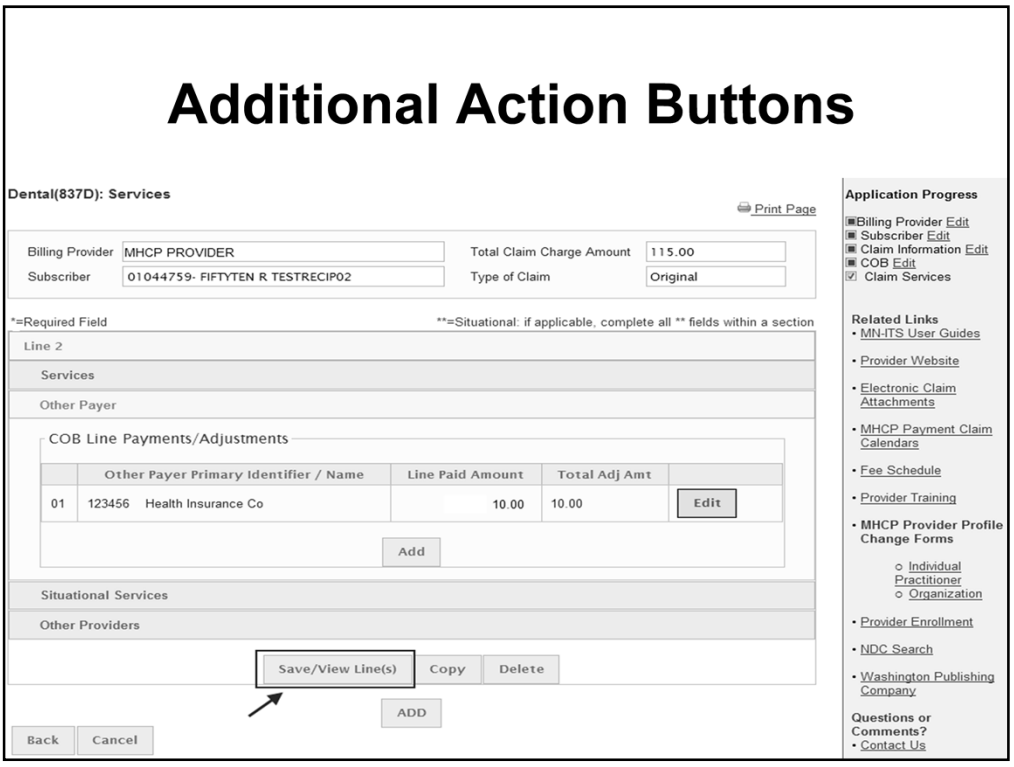
The total submitted charge for the second line was 20.00; and the total payment and adjustments amount equals 20.00.

To change or review the COB information, select **Edit** from the COB summary table . Again, only select the Add action button directly under the COB summary table if there was an additional other payer.

Additional Accordion Panels



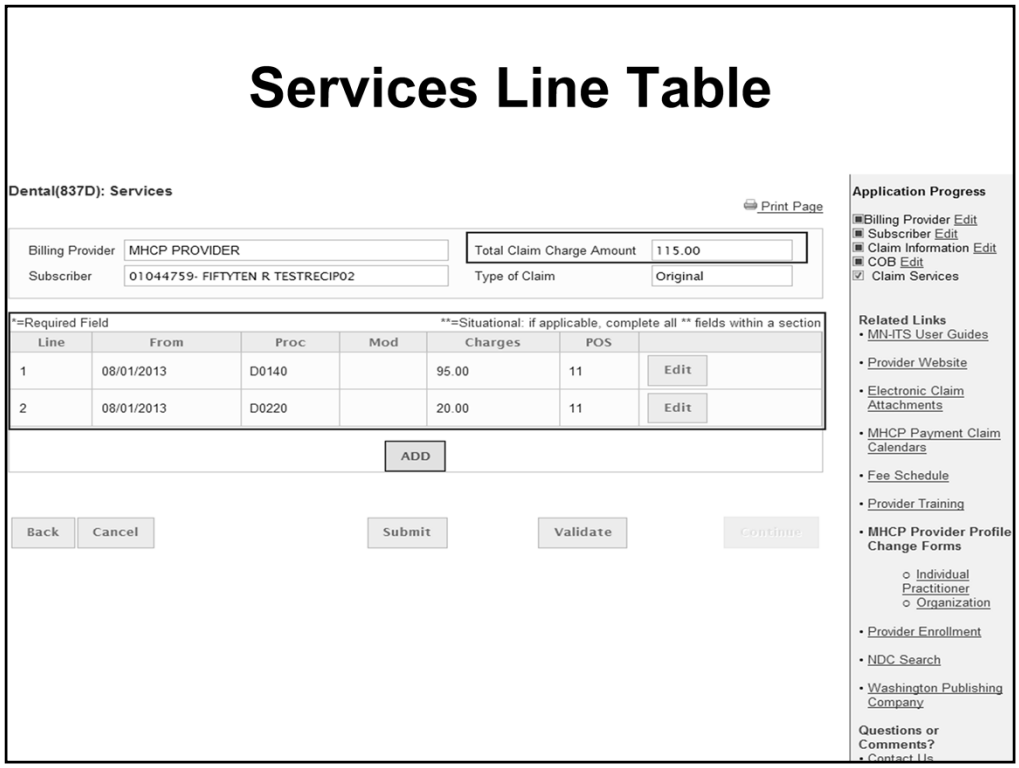
Once you have saved your second lines COB, depending on your service line you may need to add additional information to that specific line in either the Situational Services or Other Payers accordion panels.



Below the accordion panels are several action buttons. The provider can choose to **Add** a new line, **Copy** the existing line to add an additional line, **Delete** the line, or select **Save/View Line(s)** to display the service line(s) table.

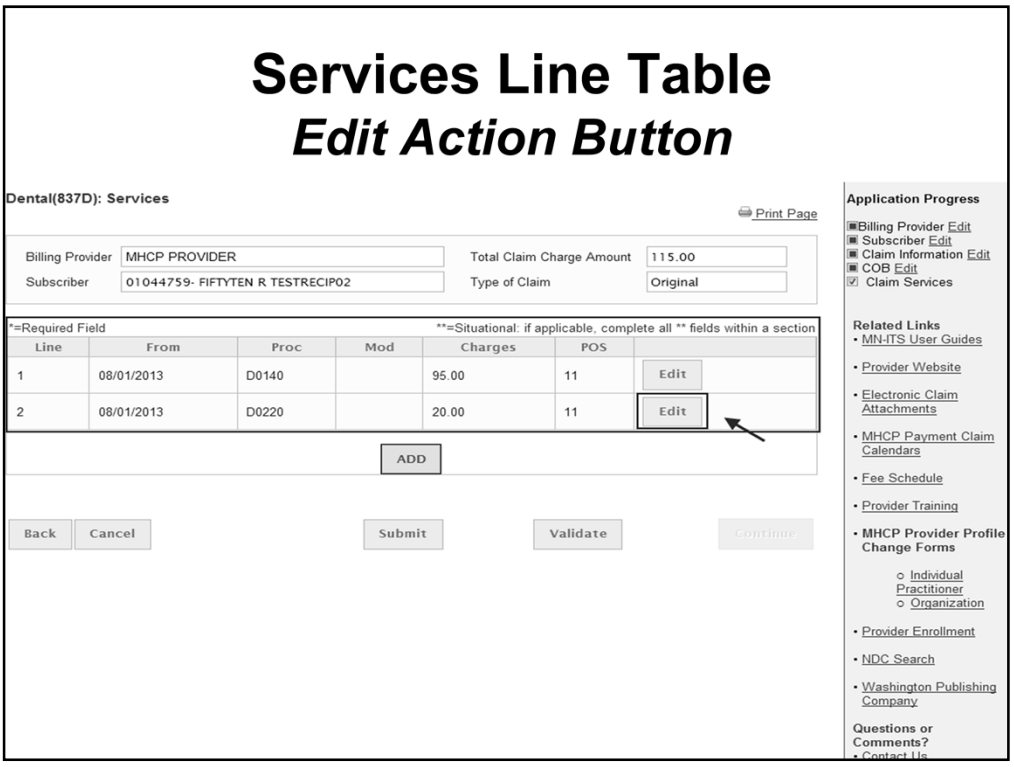
In our example we will select **Save/View Line(s)**.

Services Line Table



The Total Claim Charge Amount displays the total of both lines in the Service Line Table along with a recap of some of the information that was entered on each line.

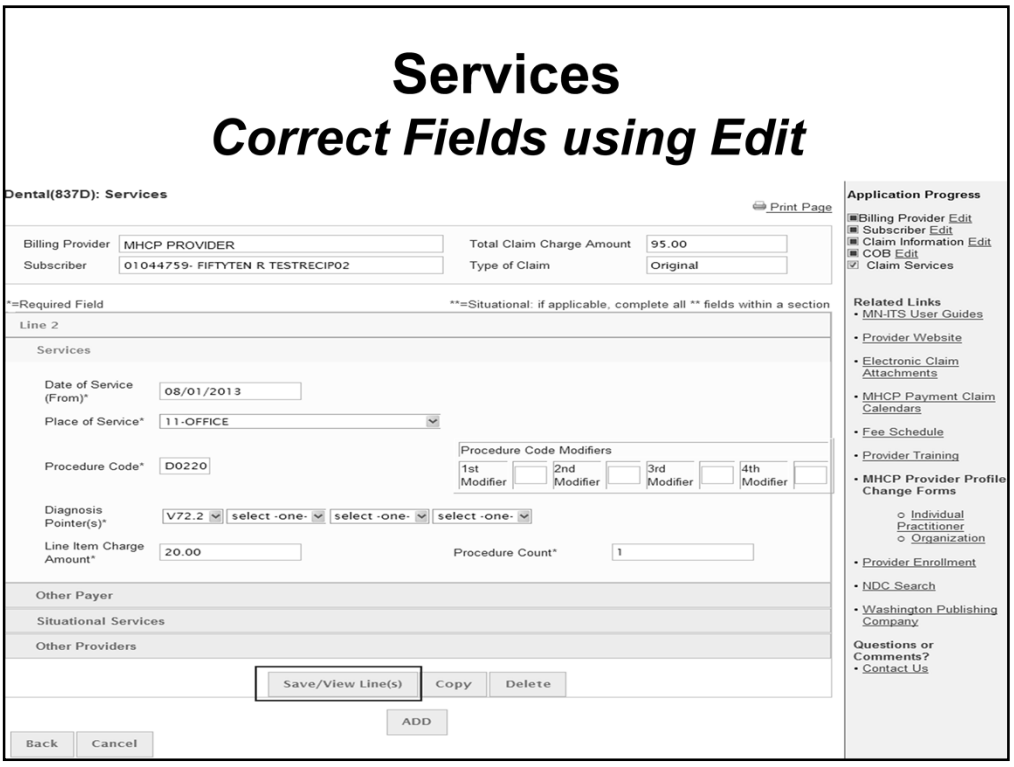
Services Line Table
Edit Action Button



Providers can use the **Edit** action button to return to an individual service line to view or correct any fields.

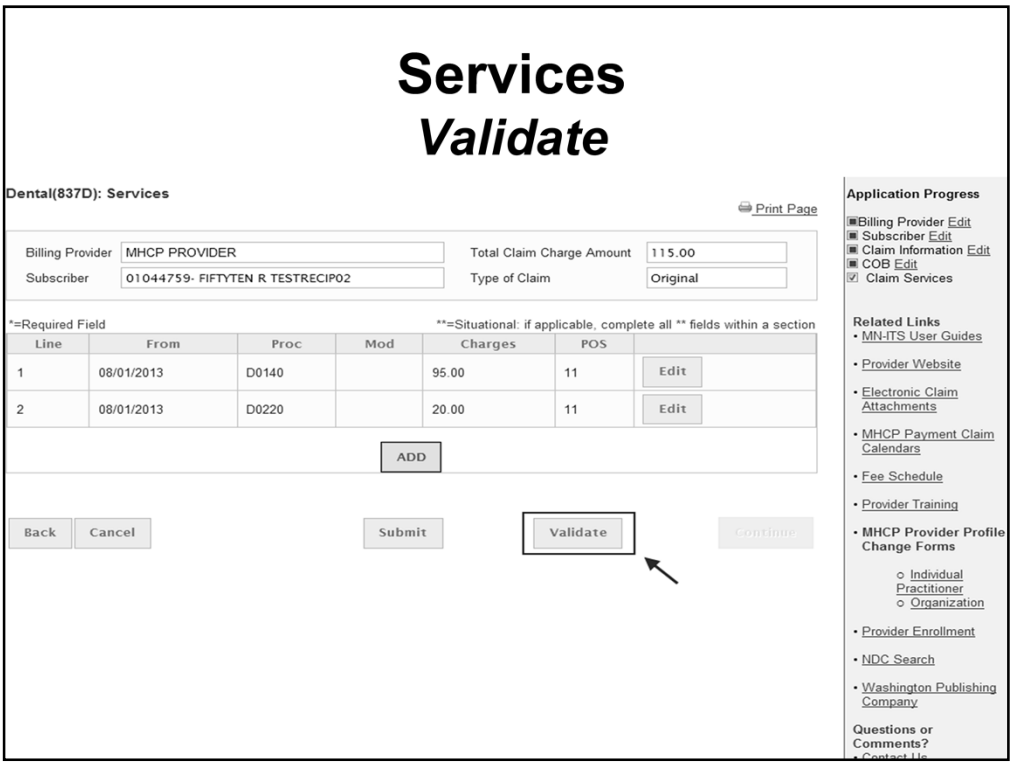
Select the **Edit** action button

Services
Correct Fields using Edit



Providers **must** re-save their line each time they view or make corrections to the service line to assure the information will be retained on the claim.

Select **Save/View Line(s)**

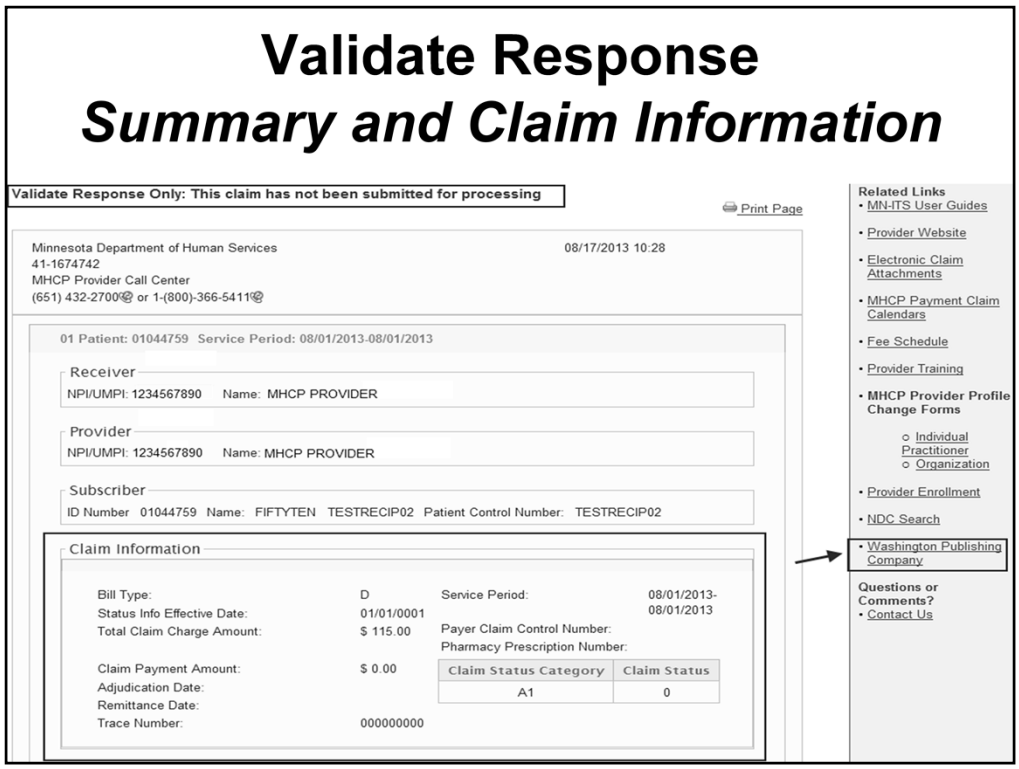


The Services Line Table will display once again for you to review your lines. Provider should Validate their claim before submitting to reduce the chance of errors or denied claims. MHCP's timely billing guidelines are as follows:

- All claims must be sent correctly, and received no later than 12 months from the date of service so they can be properly adjudicated
- Replacement claims sent to adjust a payment must be received within 6 months of the incorrect payment date, or within 12 months from the date of service, whichever is greater
- MHCP claims that were denied due to system error or incorrect information from the county; such as retroactive coverage may also be resubmitted within 12 months of the date of service or up to 6 months from date of county correction, whichever is greater. Claims related to county corrections require providers to submit a copy of the dated counties letter as supporting documentation as an electronic claims attachment
- Claims over one year old must be sent as an claims attachment with appropriate, dated documentation. MHCP will review documentation, but does not guarantee payment.

Once you select Validate you may see a message stating: Your claim is processing, please wait.

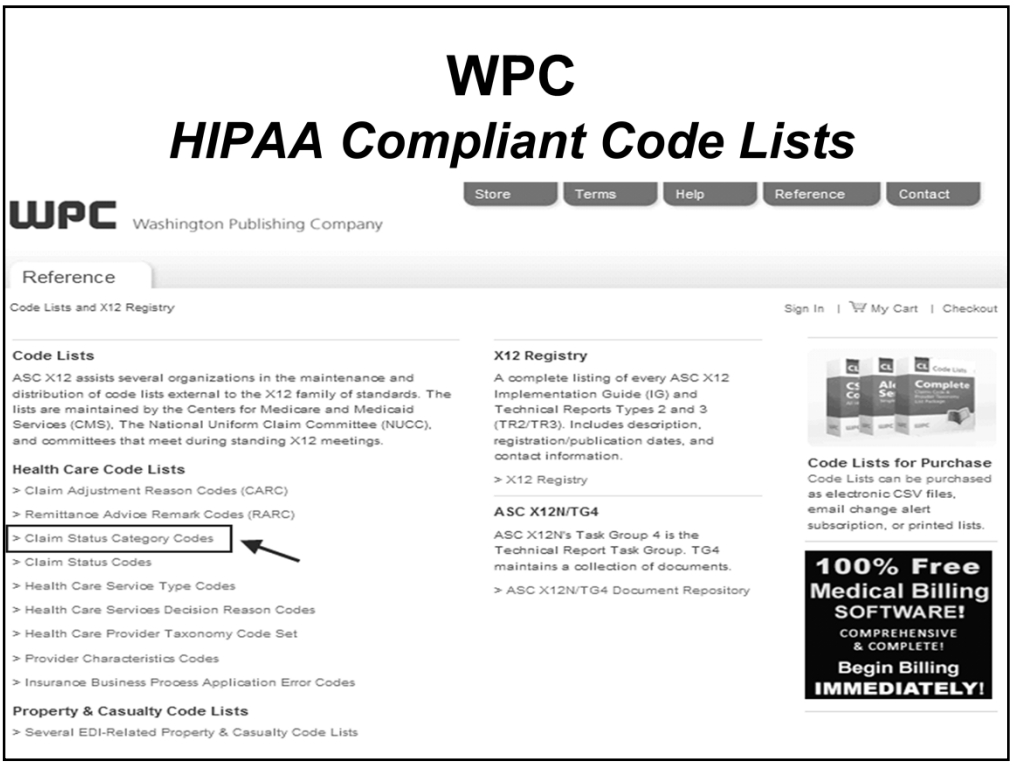
Validate Response
Summary and Claim Information



At the top of the page a message will state: Validate Response Only: This claim has not been submitted for processing.

Displayed is the Receiver and Providers NPI and name, and the Subscriber ID, name and patient control number.

In the Claim Information section, providers should review the Claim Status Category and Claim Status codes to determine if any errors exist on the claim. The HIPAA compliant codes can be viewed using the right navigation menu Washington Publishing Company link to look up the codes.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WPC Washington Publishing Company
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Code Lists and X12 Registry
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> Remittance Advice Remark Codes (RARC)
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> Health Care Provider Taxonomy Code Set
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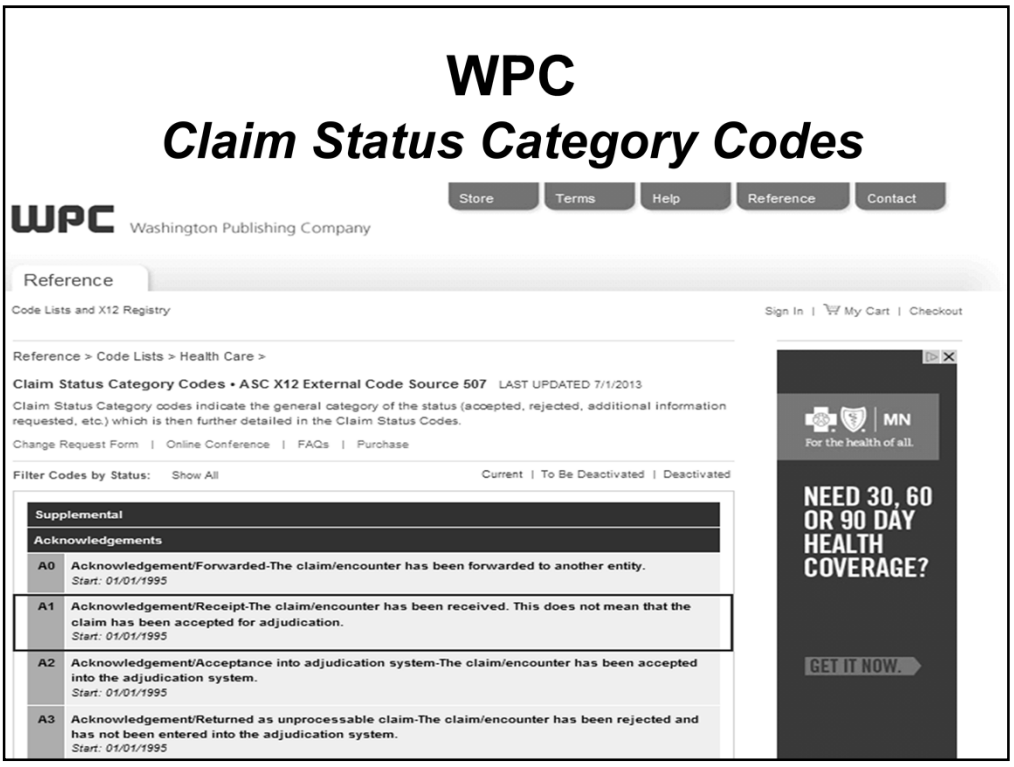
From here we will select the Claim Status Category Codes link.

WPC
Claim Status Category Codes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Code Lists and X12 Registry
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Reference > Code Lists > Health Care >
Claim Status Category Codes • ASC X12 External Code Source 507 LAST UPDATED 7/1/2013
Claim Status Category codes indicate the general category of the status (accepted, rejected, additional information requested, etc.) which is then further detailed in the Claim Status Codes.
Change Request Form | Online Conference | FAQs | Purchase
Filter Codes by Status: Show All
Current | To Be Deactivated | Deactivated
Supplemental
Acknowledgements
A0 Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity.
Start: 01/01/1995
A1 Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
Start: 01/01/1995
A2 Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system.
Start: 01/01/1995
A3 Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.
Start: 01/01/1995
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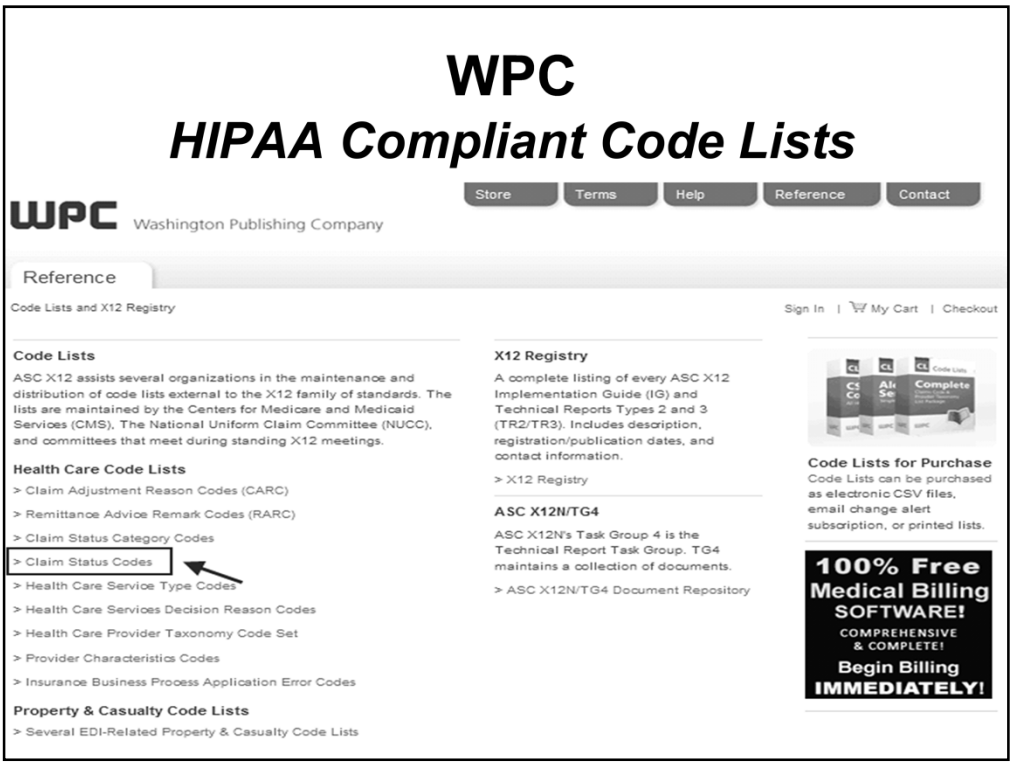
In the Claim Information our claim status category code is A1, which means that the claim has been acknowledged, but not accepted for adjudication.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Back on the WPC code list we now select the claim status codes link.

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Code Lists and X12 Registry
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Health Care Claim Status Codes • ASC X12 External Code Source 508 LAST UPDATED 7/1/2013
Health Care Claim Status Codes convey the status of an entire claim or a specific service line.
Change Request Form | Online Conference | FAQs | Purchase
Filter Codes by Status: Show All
Current | To Be Deactivated | Deactivated
0 Cannot provide further status electronically.
Start: 01/01/1995
1 For more detailed information, see remittance advice.
Start: 01/01/1995
2 More detailed information in letter.
Start: 01/01/1995
3 Claim has been adjudicated and is awaiting payment cycle.
Start: 01/01/1995
6 Balance due from the subscriber.
Start: 01/01/1995
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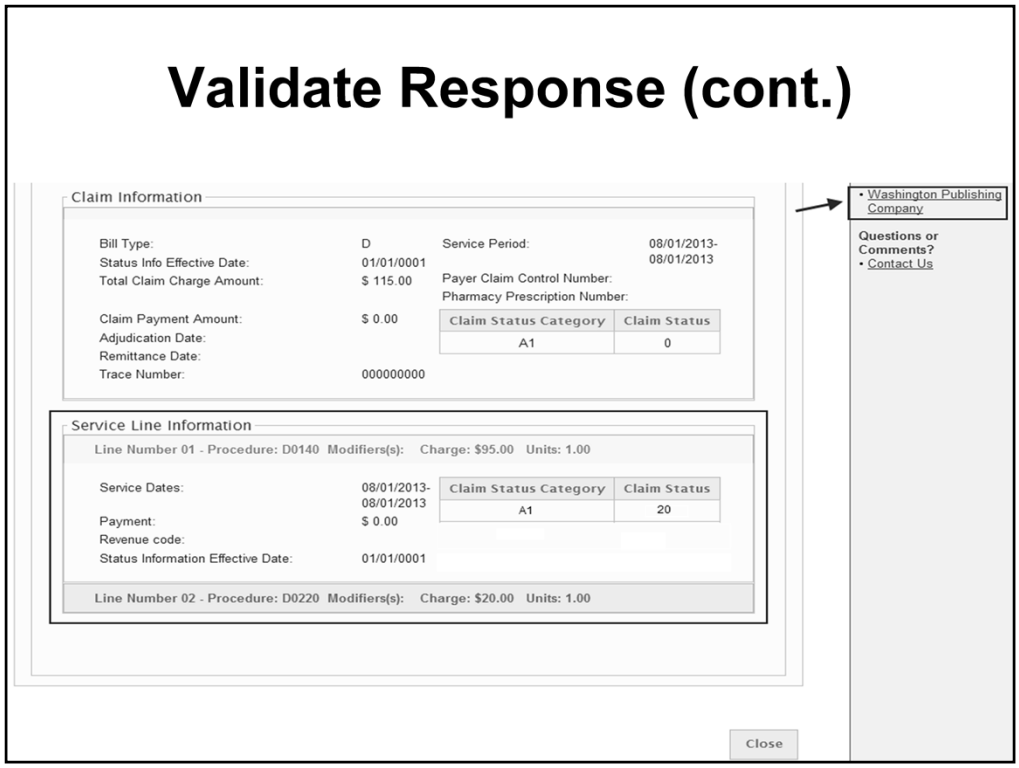
The claim status code 0 tells us the because the claim is in a validate status the claims system cannot provide further status electronically.

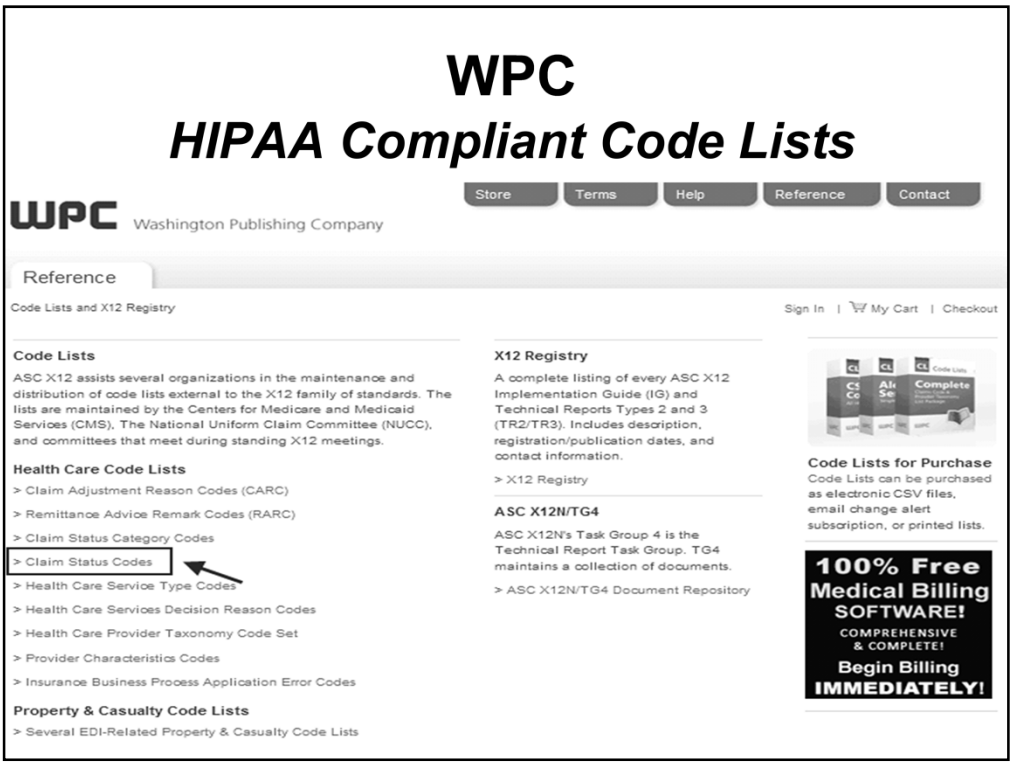
Now we will close the WPC code list and return to the validate response to review the service line status codes.

Validate Response (cont.)


Claim Information
Bill Type: D
Status Info Effective Date: 01/01/0001
Total Claim Charge Amount: $ 115.00
Claim Payment Amount: $ 0.00
Adjudication Date:
Remittance Date:
Trace Number: 000000000
Service Period: 08/01/2013-08/01/2013
Payer Claim Control Number:
Pharmacy Prescription Number:
Claim Status Category | Claim Status
A1 | 0
Service Line Information
Line Number 01 - Procedure: D0140 Modifiers(s): Charge: $95.00 Units: 1.00
Service Dates: 08/01/2013-08/01/2013
Payment: $ 0.00
Revenue code:
Status Information Effective Date: 01/01/0001
Claim Status Category | Claim Status
A1 | 20
Line Number 02 - Procedure: D0220 Modifiers(s): Charge: $20.00 Units: 1.00
• Washington Publishing Company
Questions or Comments?
• Contact Us
Close

Each Service line will display, in accordion panel format, with their own status codes. Notice that line 2 is collapsed. Remember to select each line to review both of the claim status codes using the WPC link on the right navigation menu.

We know that A1 means that the claim has been acknowledged, but not accepted for adjudication. So next lets look at the WPC code list to review the claim status 20.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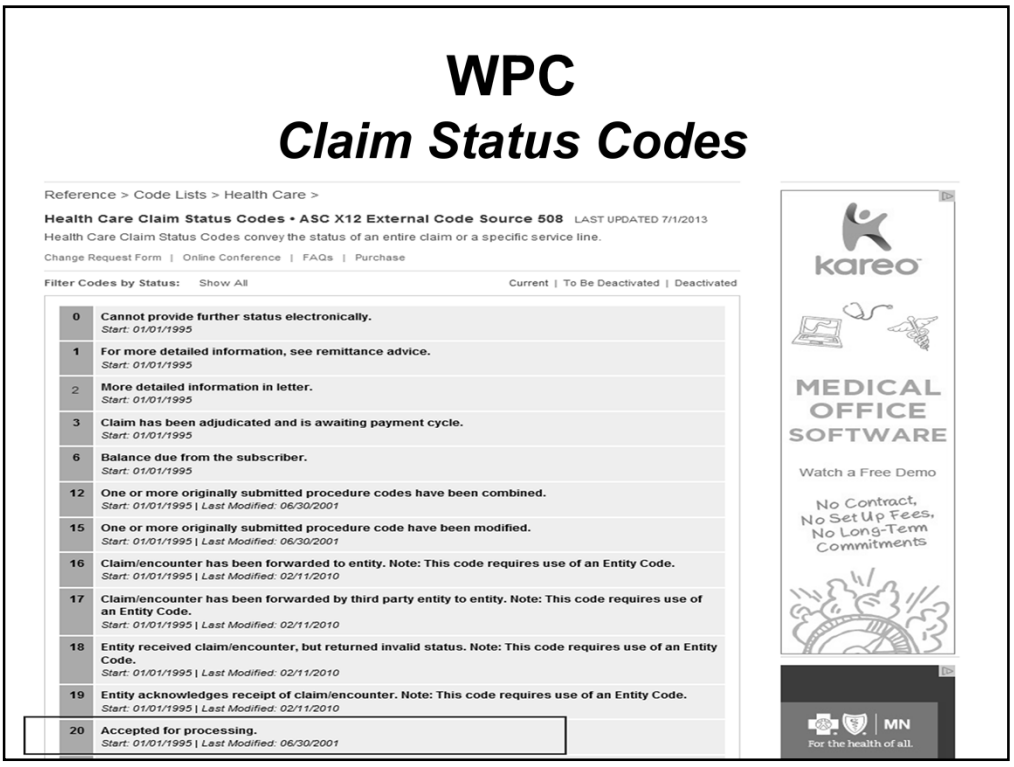
Select the claim status codes link.


WPC
Claim Status Codes
Reference > Code Lists > Health Care >
Health Care Claim Status Codes • ASC X12 External Code Source 508 LAST UPDATED 7/1/2013
Health Care Claim Status Codes convey the status of an entire claim or a specific service line.
Change Request Form | Online Conference | FAQs | Purchase
Filter Codes by Status: Show All
Current | To Be Deactivated | Deactivated
0 Cannot provide further status electronically.
Start: 01/01/1995
1 For more detailed information, see remittance advice.
Start: 01/01/1995
2 More detailed information in letter.
Start: 01/01/1995
3 Claim has been adjudicated and is awaiting payment cycle.
Start: 01/01/1995
6 Balance due from the subscriber.
Start: 01/01/1995
12 One or more originally submitted procedure codes have been combined.
Start: 01/01/1995 | Last Modified: 06/30/2001
15 One or more originally submitted procedure code have been modified.
Start: 01/01/1995 | Last Modified: 06/30/2001
16 Claim/encounter has been forwarded to entity. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
17 Claim/encounter has been forwarded by third party entity to entity. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
18 Entity received claim/encounter, but returned invalid status. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
19 Entity acknowledges receipt of claim/encounter. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
20 Accepted for processing.
Start: 01/01/1995 | Last Modified: 06/30/2001
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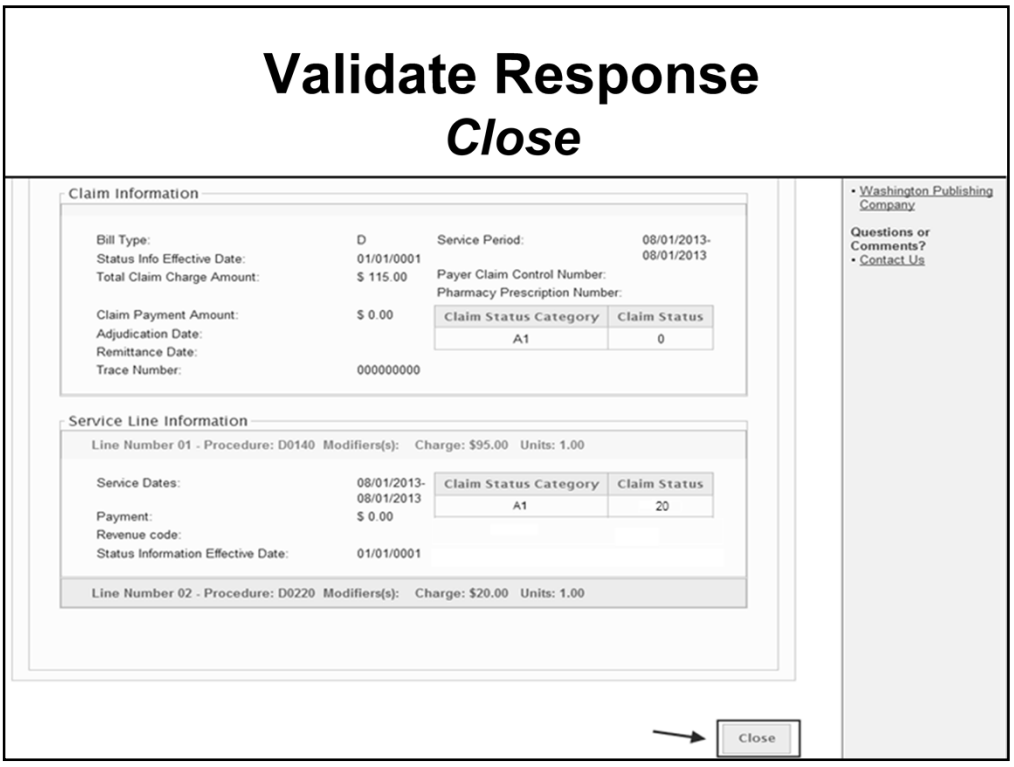
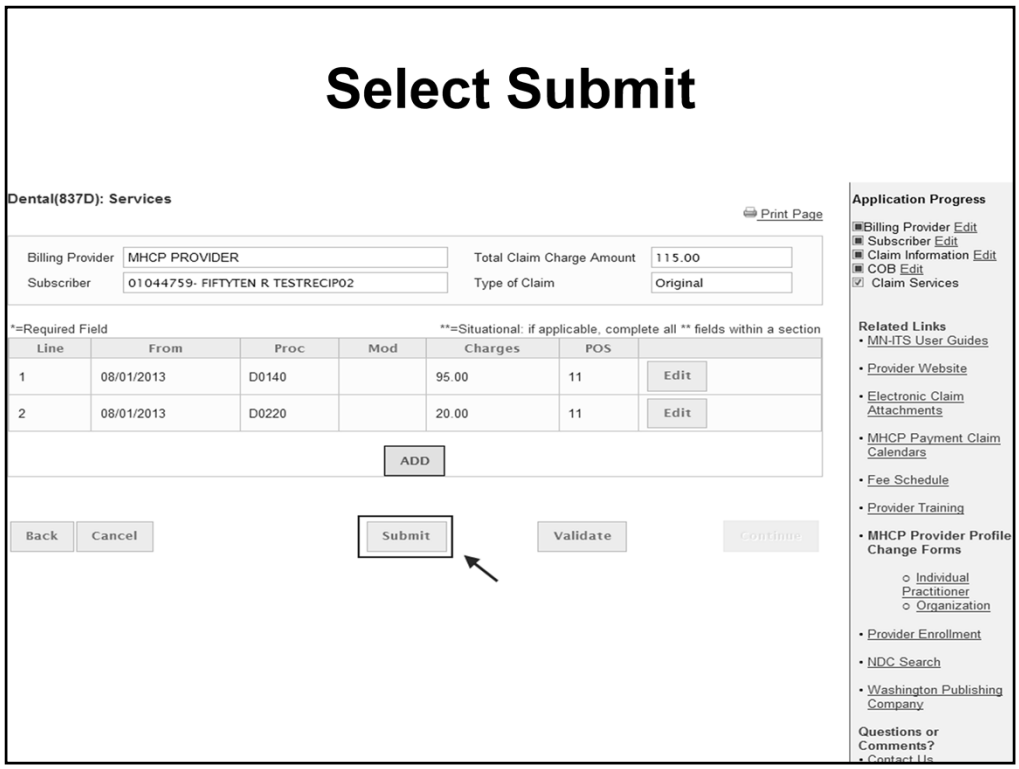
The claim status code 20 tells us the claim has been accepted for processing.

Close the WPC code list and return to the validate response.

Validate Response
Close



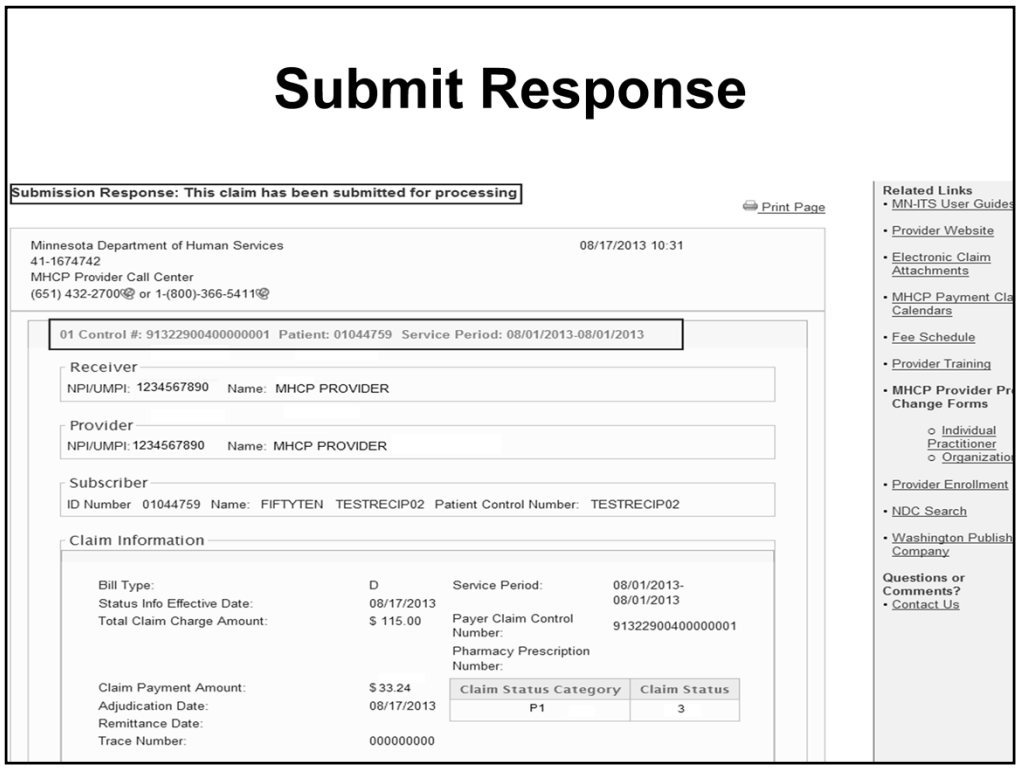
To return to the claim select the **Close** action button at the bottom right.



Back on the Services Line Table summary screen, providers may use the Application Progress feature in the upper right to return to any of the screens by selecting **Edit** next to the screen that needs to be corrected. Once the correction is made providers can once again validate their claim and review both of the claim status codes again.

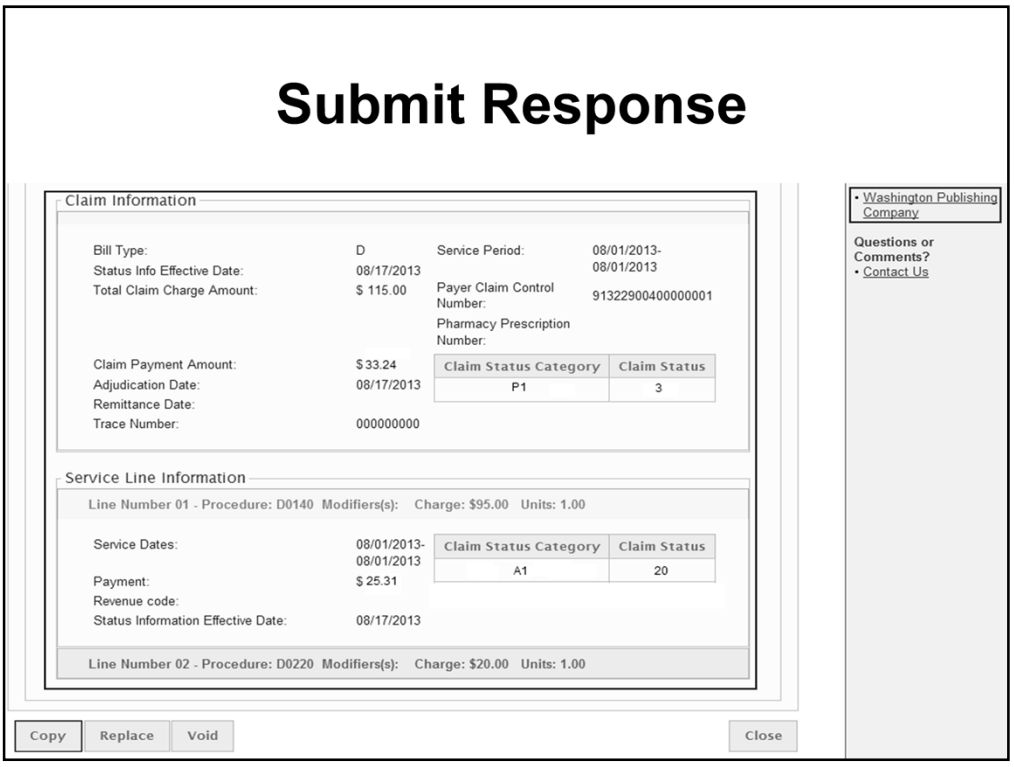
If no errors are found, select **Submit** to submit the claim to MHCP for processing.

Submit Response

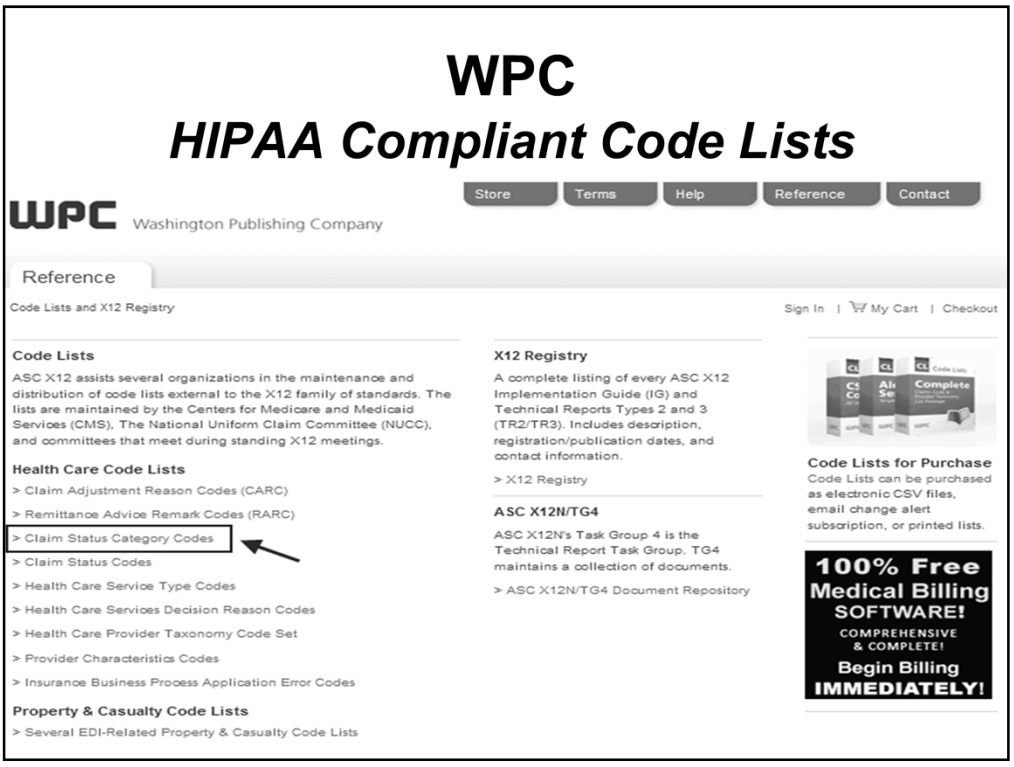


The screen now displays a message at the top stating: Submission Response: This claim has been submitted for processing.

The payer claim number (PCN) is displayed as a **control #** in orange below the MHCP contact information.



Notice the claim payment amount now displays along side the claim status codes. Next lets review the WPC code list for P1 and 3.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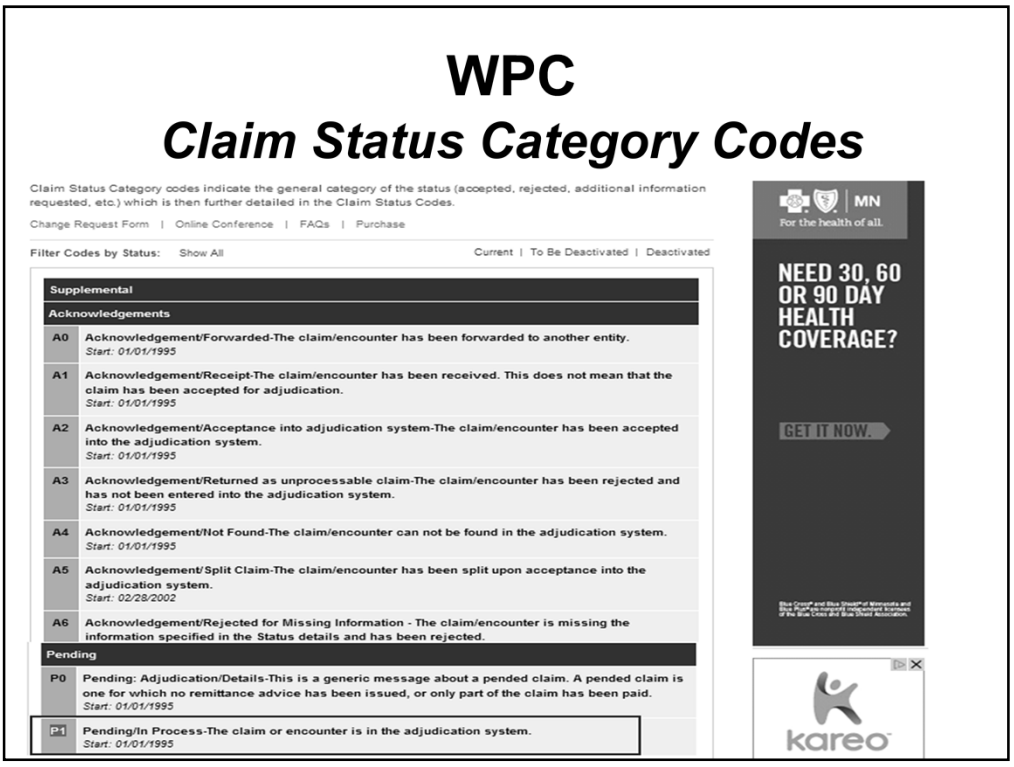
From here we will select the Claim Status Category Codes link.


WPC
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Change Request Form | Online Conference | FAQs | Purchase
Filter Codes by Status: Show All
Current | To Be Deactivated | Deactivated
Supplemental
Acknowledgements
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Start: 01/01/1995
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Start: 01/01/1995
A3 Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.
Start: 01/01/1995
A4 Acknowledgement/Not Found-The claim/encounter can not be found in the adjudication system.
Start: 01/01/1995
A5 Acknowledgement/Split Claim-The claim/encounter has been split upon acceptance into the adjudication system.
Start: 02/28/2002
A6 Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.
Pending
P0 Pending: Adjudication/Details-This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid.
Start: 01/01/1995
P1 Pending/In Process-The claim or encounter is in the adjudication system.
Start: 01/01/1995
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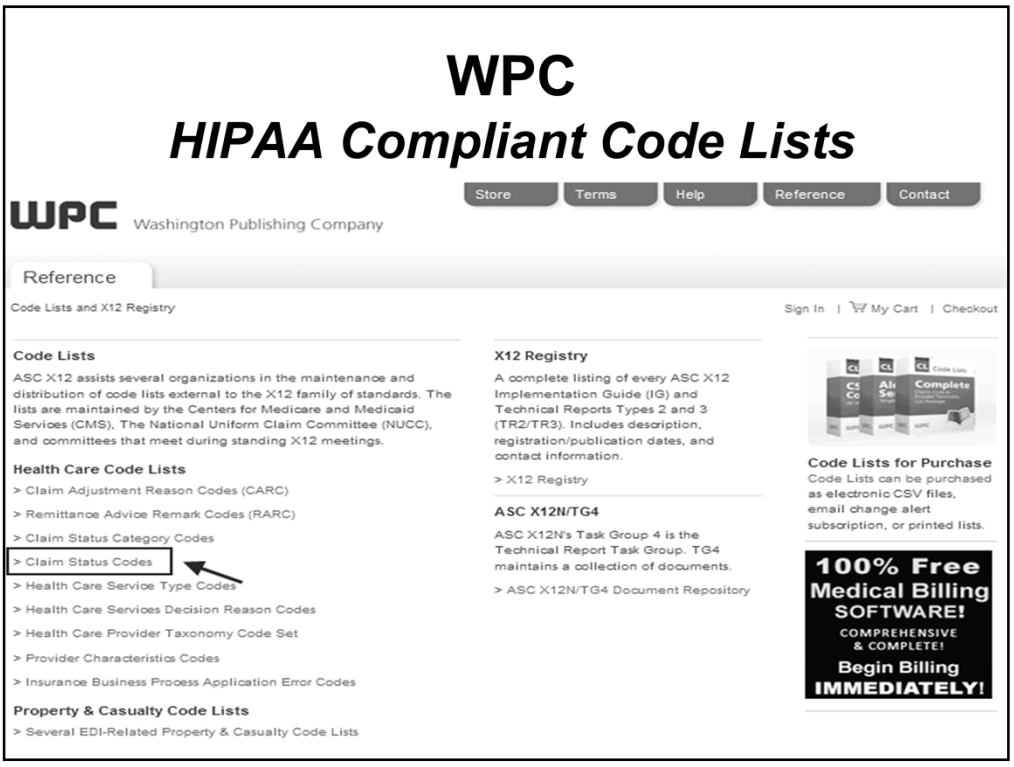
P1 indicates the claim is in a pending or in process.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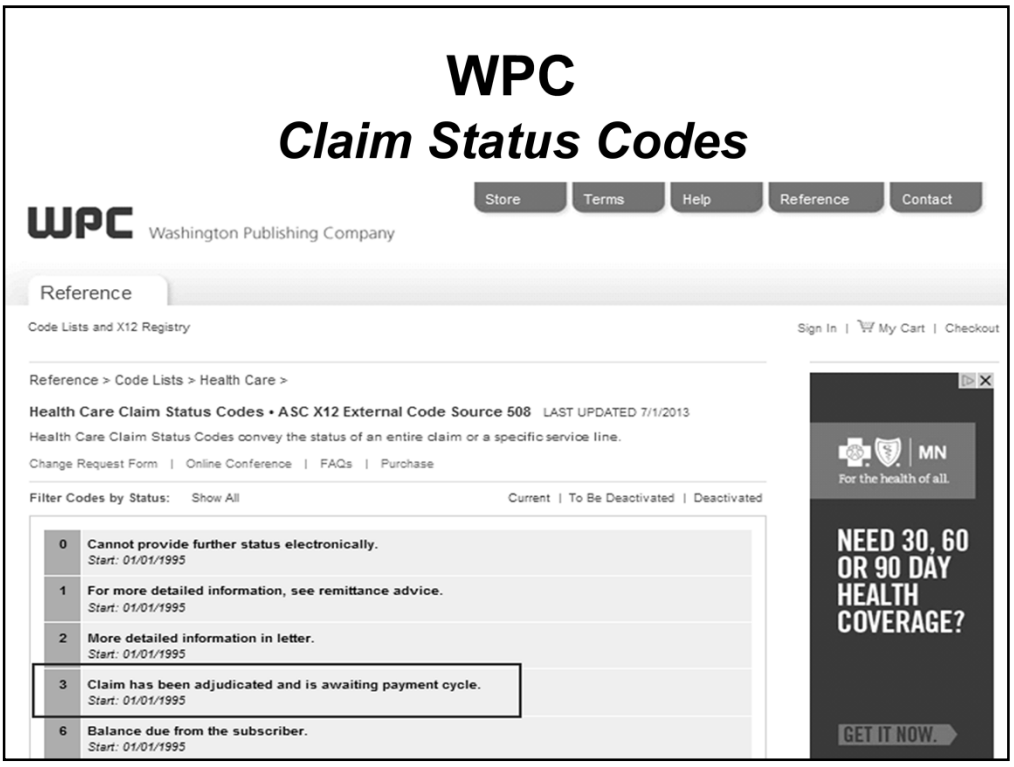
Back on the WPC code list we now select the claim status codes link.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Filter Codes by Status: Show All
Current | To Be Deactivated | Deactivated
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Start: 01/01/1995
1 For more detailed information, see remittance advice.
Start: 01/01/1995
2 More detailed information in letter.
Start: 01/01/1995
3 Claim has been adjudicated and is awaiting payment cycle.
Start: 01/01/1995
6 Balance due from the subscriber.
Start: 01/01/1995
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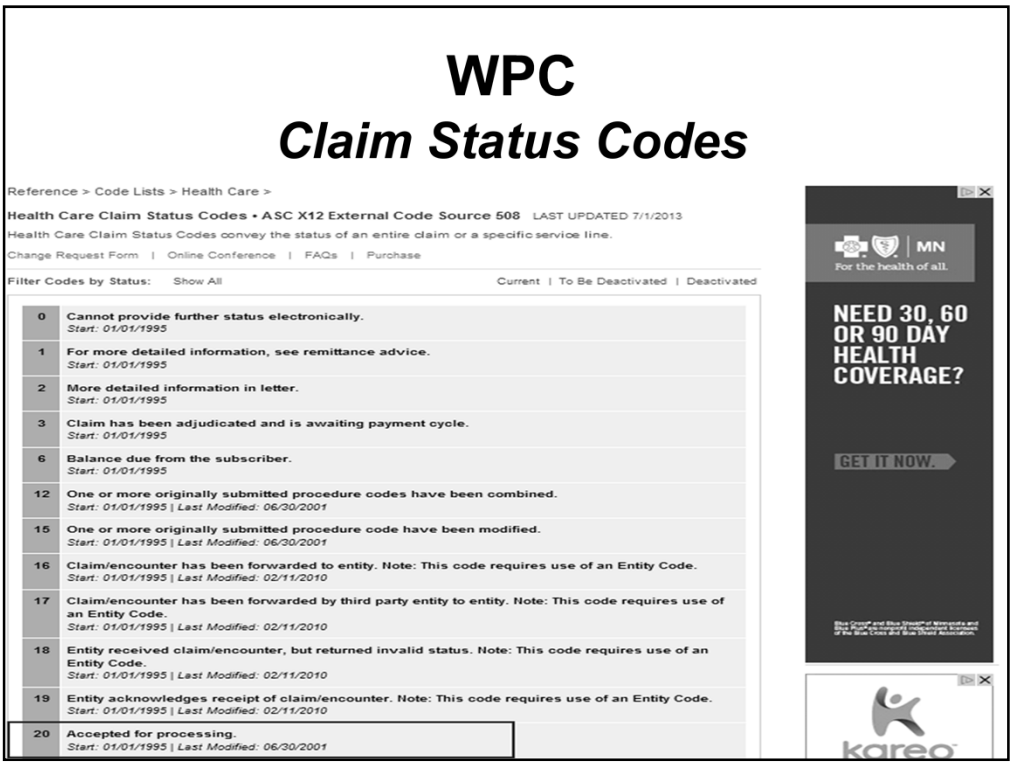
Claim status code 3 tells us the claim has been adjudicated and is awaiting the payment cycle.

The other codes on the service line were A1 and 20. We verified A1 is a good code on our validate response. Since we are still in the claim status codes list we can now verify status code 20.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Start: 01/01/1995 | Last Modified: 06/30/2001
15 One or more originally submitted procedure code have been modified.
Start: 01/01/1995 | Last Modified: 06/30/2001
16 Claim/encounter has been forwarded to entity. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
17 Claim/encounter has been forwarded by third party entity to entity. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
18 Entity received claim/encounter, but returned invalid status. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
19 Entity acknowledges receipt of claim/encounter. Note: This code requires use of an Entity Code.
Start: 01/01/1995 | Last Modified: 02/11/2010
20 Accepted for processing.
Start: 01/01/1995 | Last Modified: 06/30/2001
MN
For the health of all.
NEED 30, 60 OR 90 DAY HEALTH COVERAGE?
GET IT NOW.
kareo

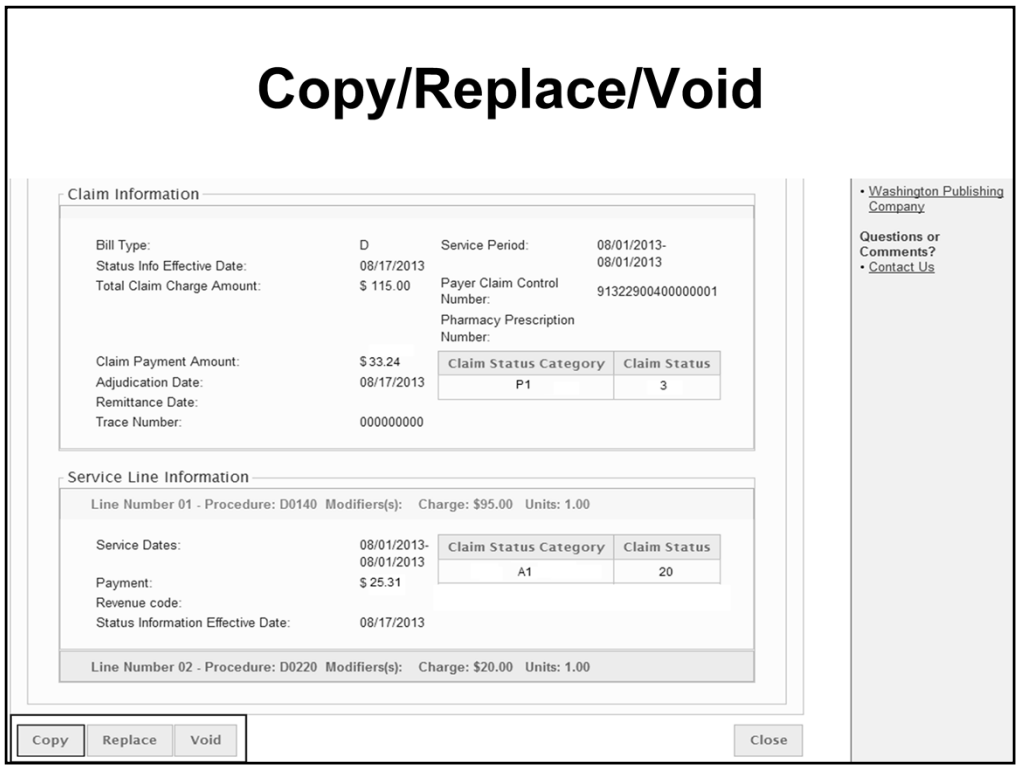
The Claim Status Code 20 tells us the our claim has been accepted for processing.

With the new screens you may notice several new claim status category and claim status codes other than F1 and 65.

Remember the Washington Publishing Company link is always available on the right side to assist staff determine how the line was processed.

Additional lines display as collapsed accordion panels in blue with the line number and a general summary. Providers must select each line to review the codes and payment information to thoroughly understand how the entire claim was processed.

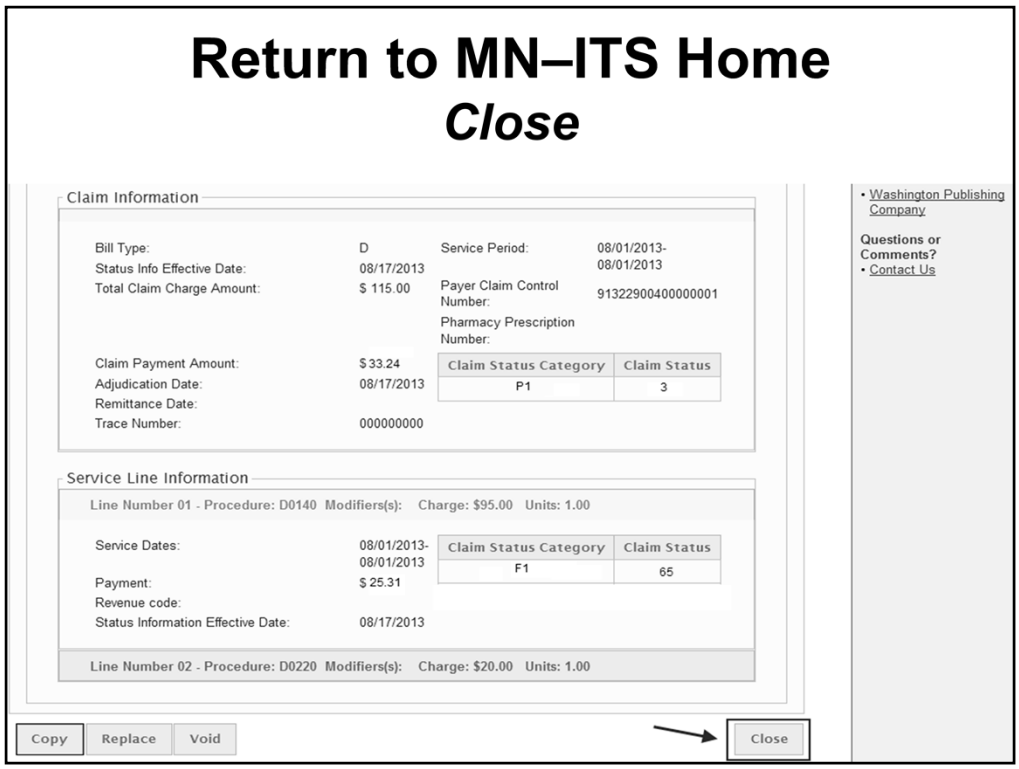
Copy/Replace/Void



At the bottom left side providers will have the option to Copy, Replace or Void the claim. This new feature will retrieve all of the entries that were made on the claim that was just submitted.

Refer to our Copy Replace and Void MN–ITS user guide for instructions.

Return to MN–ITS Home
Close

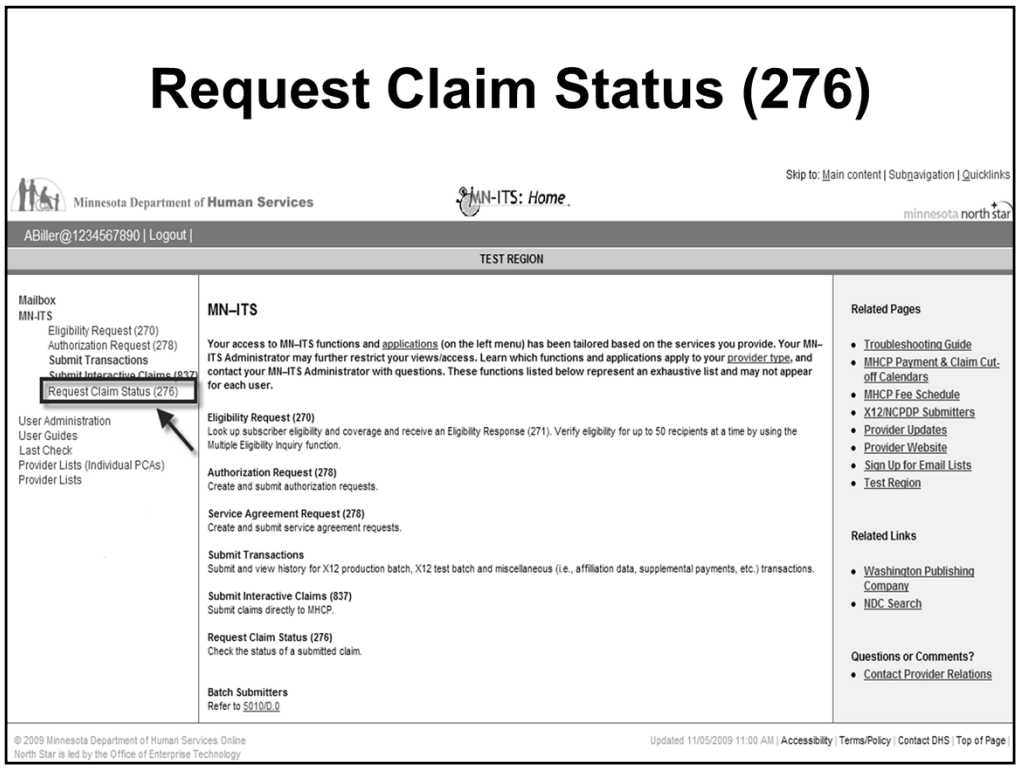


When you are done reviewing the submit response, select **Close** to return to the MN-ITS Home page.

New MN–ITS Dental Claim Screens

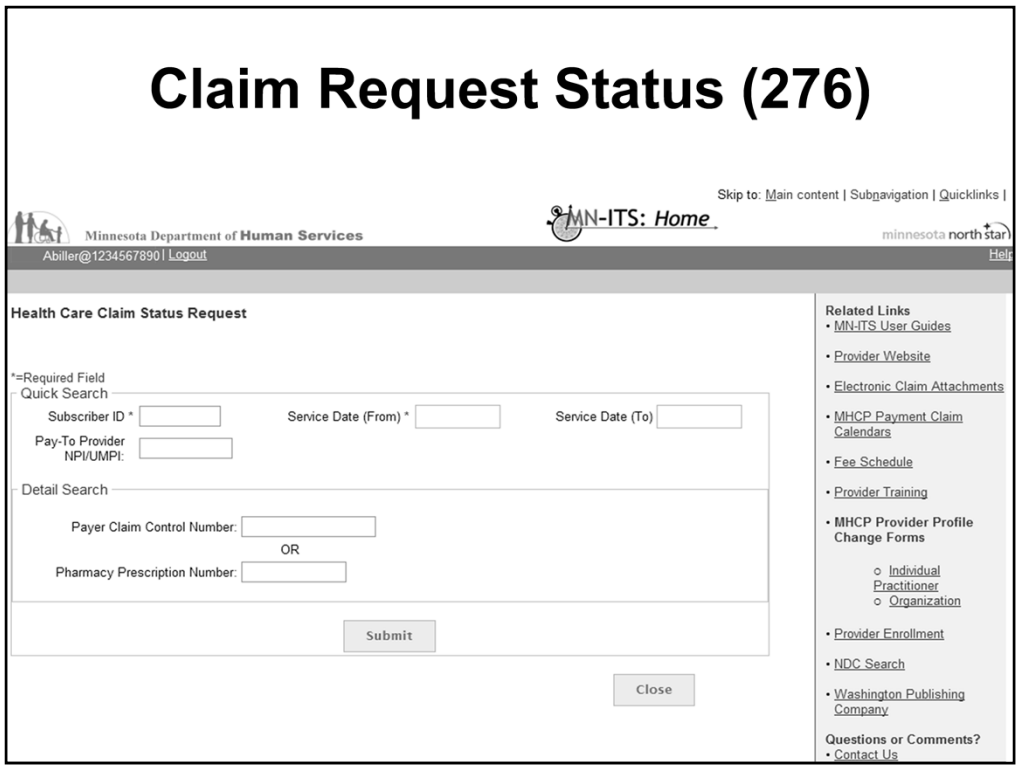
Minnesota Health Care Programs

Before we go into the new MN–ITS screens for the Request Claim Status (276/277); I would like to welcome any questions you may have about the new MN–ITS Dental Claim screens. Use the chat feature at the bottom left, select the private tab and send your question to the leader and assistance group?


Request Claim Status (276)
Skip to: Main content | Subnavigation | Quicklinks
Minnesota Department of Human Services
MN-ITS: Home
minnesota north star
ABiller@1234567890 | Logout |
TEST REGION
Mailbox
MN-ITS
Eligibility Request (270)
Authorization Request (278)
Submit Transactions
Request Claim Status (276)
User Administration
User Guides
Last Check
Provider Lists (Individual PCAs)
Provider Lists
MN–ITS
Your access to MN–ITS functions and applications (on the left menu) has been tailored based on the services you provide. Your MN–ITS Administrator may further restrict your views/access. Learn which functions and applications apply to your provider type, and contact your MN–ITS Administrator with questions. These functions listed below represent an exhaustive list and may not appear for each user.
Eligibility Request (270)
Look up subscriber eligibility and coverage and receive an Eligibility Response (271). Verify eligibility for up to 50 recipients at a time by using the Multiple Eligibility Inquiry function.
Authorization Request (278)
Create and submit authorization requests.
Service Agreement Request (278)
Create and submit service agreement requests.
Submit Transactions
Submit and view history for X12 production batch, X12 test batch and miscellaneous (i.e., affiliation data, supplemental payments, etc.) transactions.
Submit Interactive Claims (837)
Submit claims directly to MHCP.
Request Claim Status (276)
Check the status of a submitted claim.
Batch Submitters
Refer to 5010/D.0
Related Pages
Troubleshooting Guide
MHCP Payment & Claim Cut-off Calendars
MHCP Fee Schedule
X12/NCPDP Submitters
Provider Updates
Provider Website
Sign Up for Email Lists
Test Region
Related Links
Washington Publishing Company
NDC Search
Questions or Comments?
Contact Provider Relations
© 2009 Minnesota Department of Human Services Online
North Star is led by the Office of Enterprise Technology
Updated 11/05/2009 11:00 AM | Accessibility | Terms/Policy | Contact DHS | Top of Page

Now we are going to take a look at the new layout and functionality of the Request Claim Status transaction. From the MN-ITS Home page left navigation menu select **Request Claim Status (276).**

Claim Request Status (276)



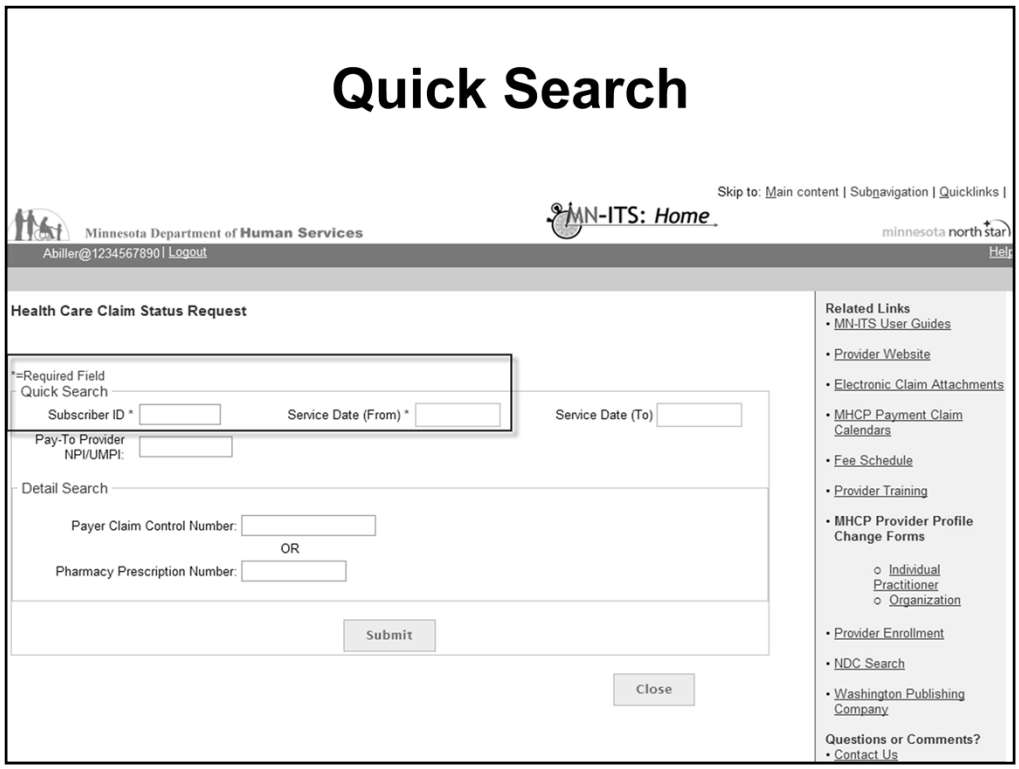
This is the new layout of the Request Status transaction. Changes were made to follow the new 5010 electronic billing requirements.

New is the **Pay-To Provider NPI/UMPI** field where billing agencies, clearinghouses, and other billing organizations who submit claims on a providers behalf will now be able to retrieve those claims they submitted by entering their NPI or UMPI.

New to the Claims Request Status feature in MN–ITS is the capability to Copy, replace or void all dental claims. This includes claims submitted using MN–ITS Direct Data Entry or Batch claims sent electronically by a billing organization or clearinghouse that are uploaded through MN–ITS Submit Transactions secure FTP file.

Up to three years of claims history can be retrieved.

Quick Search

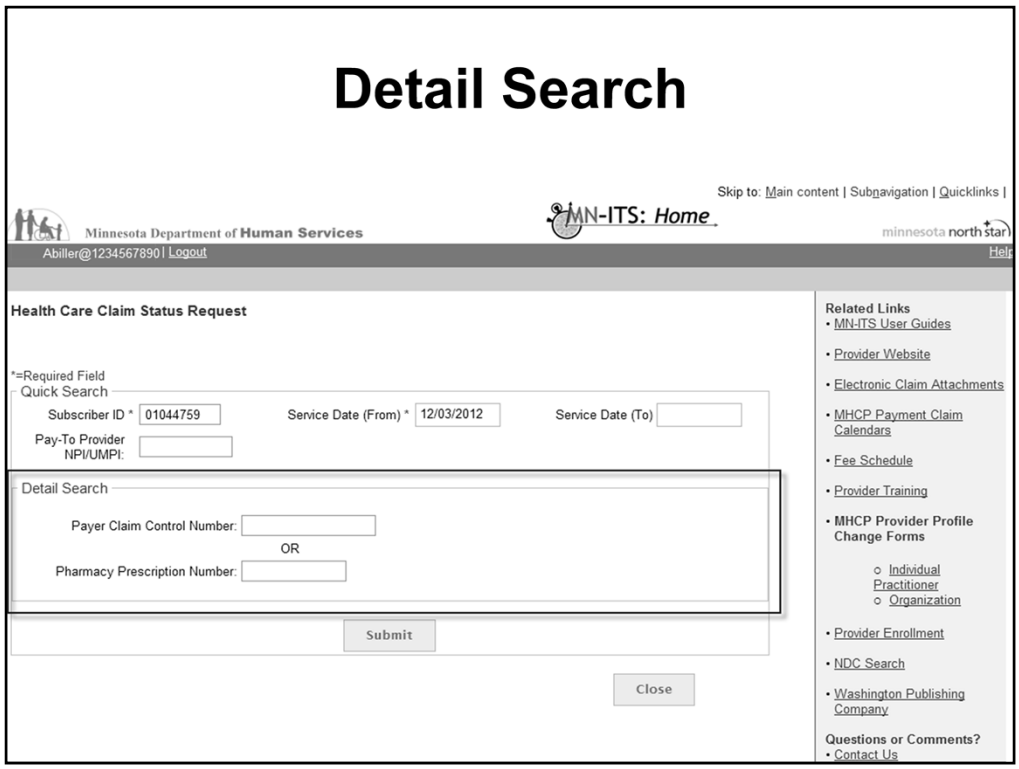


The New Quick Search section has two fields that are always required, **Subscriber ID** and **Service Date (From).**

The service date from is the first date of service on the claim, or the first date within a range of dates you are requesting.

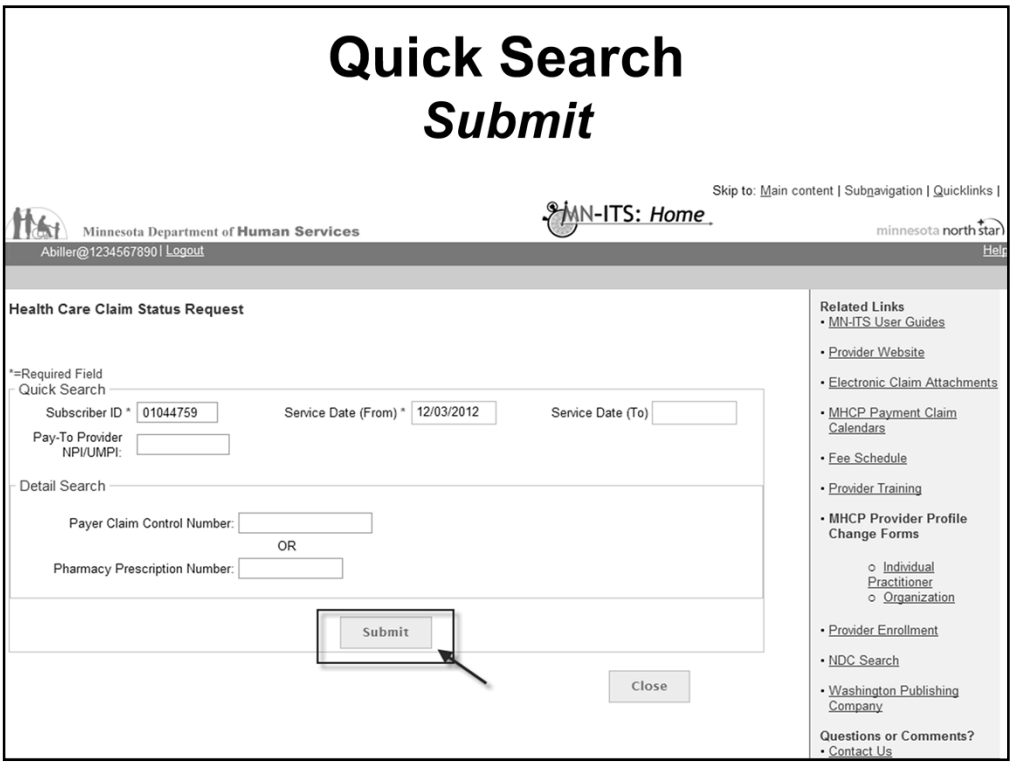
The **Service Date (To)** can be left blank and will be defaulted with the From date; or you may enter a different date to search for a span of dates.

Using a span of dates may result in multiple claim responses being displayed.

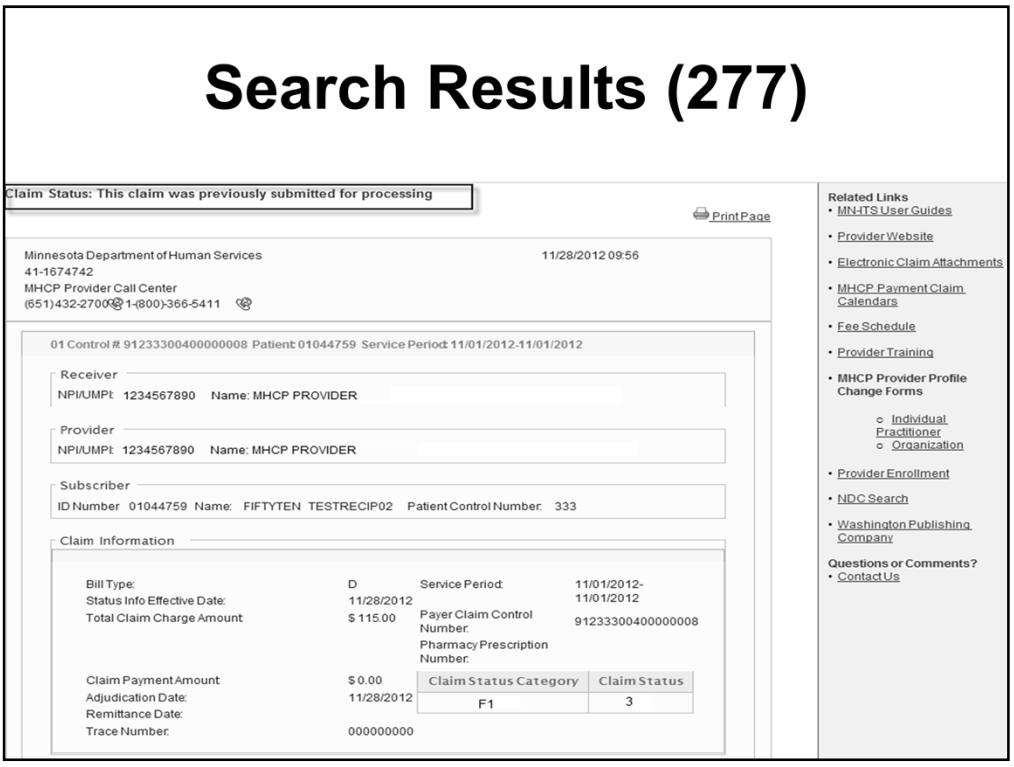


In addition to completing the required fields you can choose to narrow your search criteria by using the Detail Search section to enter the Payer Claim Number of the claim you are requesting.

Quick Search
Submit



After the information has been entered, select **Submit**.



The search results will display a single response for the claim that matches your search, or if multiple claims match your search entry, they will display in an accordion panel format. The response opens with the first claim, and displays the additional claims as a collapsed accordion in blue with a search result number and Control # of the claim.

Only the 10 most recently processed claims for the search criteria used will display in the search results. Be sure to narrow your search by entering as much information as you have into the search fields.

At the top of the screen a message displays stating: Claim Status: This claim was previously submitted for processing.

If you want to return to the Request Claim Status, simply close the response page.

New MN–ITS Screens (837D) Dental

Any Questions?

Thank you, and remember to visit our Website: www.dhs.state.mn.us/provider

Minnesota Health Care Programs (MHCP)
Minnesota Department of Human Services
Provider Relations – 2012 & 2013

Additional trainings and webinars are available and listed on the Provider Training page, which is located under Communications link on our MHCP Enrolled Providers website.

FOR THE WEBINAR ONLY

We will take a brief 10 minute break before we begin our question and answer session. Please remember to submit any questions to the Leaders and Assistants group, using the webinar chat feature.

Thank you for attending the 837D Dental webinar for the layout and functionality of the new MN–ITS Screens.